2014

CUMULATIVE SUPPLEMENT

TO

MISSISSIPPI CODE

1972 ANNOTATED

Issued September 2014

CONTAINING PERMANENT PUBLIC STATUTES OF MISSISSIPPI
ENACTED THROUGH THE 2014 REGULAR SESSION
AND 1ST AND 2ND EXTRAORDINARY SESSIONS

PUBLISHED BY AUTHORITY OF
THE LEGISLATURE

SUPPLEMENTING

Volume 19

Title 83 (Chapters 1 to 20)

(As Revised 2011)

For latest statutes or assistance call 1-800-833-9844

By the Editorial Staff of the Publisher

LexisNexis®

QUESTIONS ABOUT THIS PUBLICATION?

For EDITORIAL QUESTIONS concerning this publication, or REPRINT PERMISSION, please call:
800-833-9844

For CUSTOMER SERVICE ASSISTANCE concerning replacement pages, shipments, billing or other matters, please call:

Customer Service Department at	800-833-9844
Outside the United States and Canada	518-487-3000
FAX	518-487-3584

For INFORMATION ON OTHER MATTHEW BENDER PUBLICATIONS, please call:

Your account manager or	800-223-1940
Outside the United States and Canada	518-487-3000

5462225

ISBN 978-0-327-09628-3 (Code set)
ISBN 978-1-4224-9455-4 (Volume 19)

Matthew Bender & Company, Inc.

701 Water Street, Charlottesville, VA 22902-5389

www.lexisnexis.com

(Pub.44510)

User's Guide

In order to assist both the legal profession and the layman in obtaining the maximum benefit from the Mississippi Code of 1972 Annotated, a User's Guide has been included in the main volume. This guide contains comments and information on the many features found within the Code intended to increase the usefulness of the Code to the user.

PUBLISHER'S FOREWORD

Statutes

The 2014 Supplement to the Mississippi Code of 1972 Annotated reflects the statute law of Mississippi as amended by the Mississippi Legislature through the end of the 2014 Regular Session and 1st and 2nd Extraordinary Sessions.

Annotations

Case annotations are included based on decisions of the State and federal courts in cases arising in Mississippi. Annotations to collateral research references are also included.

To better serve our customers by making our annotations more current, LexisNexis has changed the sources that are read to create annotations for this publication. Rather than waiting for cases to appear in printed reporters, we now read court decisions as they are released by the courts. A consequence of this more current reading of cases, as they are posted online on LexisNexis, is that the most recent cases annotated may not yet have print reporter citations. These will be provided, as they become available, through later publications.

This publication contains annotations taken from decisions of the Mississippi Supreme Court and the Court of Appeals and decisions of the appropriate federal courts. These cases will be printed in the following reporters:

Southern Reporter, 3rd Series
United States Supreme Court Reports
Supreme Court Reporter
United States Supreme Court Reports, Lawyers' Edition, 2nd Series
Federal Reporter, 3rd Series
Federal Supplement, 2nd Series
Federal Rules Decisions
Bankruptcy Reporter

Additionally, annotations have been taken from the following sources:

American Law Reports, 6th Series
American Law Reports, Federal 2nd
Mississippi College Law Review
Mississippi Law Journal

Finally, published opinions of the Attorney General and opinions of the Ethics Commission have been examined for annotations.

Amendment Notes

Amendment notes detail how the new legislation affects existing sections.

Editor's Notes

Editor's notes summarize subject matter and legislative history of repealed sections, provide information as to portions of legislative acts that have not been codified, or explain other pertinent information.

Joint Legislative Committee Notes

Joint Legislative Committee notes explain codification decisions and corrections of Code errors made by the Mississippi Joint Legislative Committee on Compilation, Revision, and Publication of Legislation.

Tables

The Statutory Tables volume adds tables showing disposition of legislative acts through the 2014 Regular Session and 1st and 2nd Extraordinary Sessions.

Index

The comprehensive Index to the Mississippi Code of 1972 Annotated is replaced annually, and we welcome customer suggestions. The foreword to the Index explains our indexing principles, suggests guidelines for successful index research, and provides methods for contacting indexers.

Acknowledgements

The publisher wishes to acknowledge the cooperation and assistance rendered by the Mississippi Joint Legislative Committee on Compilation, Revision, and Publication of Legislation, as well as the offices of the Attorney General and Secretary of State, in the preparation of this supplement.

User Information

Visit the LexisNexis website at http://www.lexisnexis.com for an online bookstore, technical support, customer support, and other company information.

For further information or assistance, please call us toll-free at (800) 833-9844, fax us toll-free at (800) 643-1280, e-mail us at customer.support@bender.com, or write to: Mississippi Code Editor, LexisNexis, 701 E. Water Street, Charlottesville, VA 22902-5389.

September 2014 LexisNexis

SCHEDULE OF NEW SECTIONS

Added in this Supplement

TITLE 83. INSURANCE

CHAPTER 6. Registration and Examination of Insurers

SEC.

83-6-26. Management of domestic insurers subject to registration.

CHAPTER 7. Life Insurance

UNCLAIMED LIFE INSURANCE BENEFITS ACT

83-7-301. Short title [Effective July 1, 2015].
83-7-303. Purpose [Effective July 1, 2015].
83-7-305. Definitions [Effective July 1, 2015].
83-7-307. Insurer conduct [Effective July 1, 2015].
83-7-309. Insurer unclaimed property reporting [Effective July 1, 2015].
83-7-311. Limitation on promulgation of rules or regulations that impose additional duties on insurers beyond those set out in Sections 83-7-301 through 83-7-313 [Effective July 1, 2015].
83-7-313. Effect of certain agreements between insurers and Commissioner of Insurance or State Treasurer [Effective July 1, 2015].

CHAPTER 9. Accident, Health and Medicare Supplement Insurance

ACCIDENT AND HEALTH INSURANCE

83-9-4. Commissioner may disapprove policy form, amendatory rider or endorsement currently in effect under certain circumstances; procedure; applicability.
83-9-6.3. Standardized prior authorization form for obtaining prior authorization for prescription drug benefits.
83-9-22. Health coverage plans prohibited from restricting coverage for medically appropriate treatment prescribed by physician based on insured's diagnosis with terminal condition.

COVERAGE FOR TELEMEDICINE SERVICES

83-9-351. Health insurance plans in Mississippi to provide coverage for telemedicine services; definitions.
83-9-353. Coverage and reimbursement for store-and-forward telemedicine services and remote patient monitoring services; definitions.

CHAPTER 11. Automobile Insurance

ARTICLE 3. UNINSURED MOTORIST COVERAGE

83-11-102. Purchase of single-limit, nonstacking uninsured motorist insurance coverage for four or more vehicles in lieu of uninsured motorists coverage for each vehicle.

MISSISSIPPI CODE 1972

ANNOTATED

VOLUME NINETEEN

TITLE 83

INSURANCE

Chapter 1.	Department of Insurance	83-1-1
Chapter 2.	Competitive Rating for Property and Casualty Insurance	83-2-1
Chapter 5.	General Provisions Relative to Insurance and Insurance Companies	83-5-1
Chapter 6.	Registration and Examination of Insurers	83-6-1
Chapter 7.	Life Insurance	83-7-1
Chapter 9.	Accident, Health and Medicare Supplement Insurance	83-9-1
Chapter 11.	Automobile Insurance	83-11-1
Chapter 17.	Insurance Agents, Solicitors, or Adjusters	83-17-1

CHAPTER 1

Department of Insurance

General Provisions	83-1-1
Comprehensive Hurricane Damage Mitigation Program	83-1-191

GENERAL PROVISIONS

SEC.

83-1-5.	Compensation and employees.
83-1-35.	Reward in case of willful destruction by fire or explosion of real or personal property within state.

§ 83-1-5. Compensation and employees.

The commissioner shall receive a compensation to be fixed by law. He is hereby authorized to employ a clerk and stenographer and an actuary at a salary to be fixed by law; and in addition shall be allowed a sufficient sum for traveling expenses and for extra clerical help. To assist the commissioner in efficiently performing the official duties imposed upon him by law, he may employ suitable and competent persons who possess the professional skill and/or expert knowledge needed to fulfill these duties. The State Personnel Board, based upon its findings of fact, shall exempt these persons from the provisions of Section 25-3-39 when the acquisition of such professional services is precluded based on the prevailing wage in the relevant labor market,

provided such compensation shall not, directly or indirectly, be in excess of the salary authorized to be paid to the deputy commissioner.

SOURCES: Codes, 1906, § 2553; Hemingway's 1917, § 5017; 1930, § 5116; 1942, § 5618; Laws, 1926, ch. 345; reenacted without change, Laws, 1982, ch. 375, § 2; reenacted without change, Laws, 1990, ch. 559, § 3; reenacted without change, Laws, 1996, ch. 313, § 3; Laws, 2012, ch. 546, § 42; Laws, 2014, ch. 396, § 1, eff from and after passage (approved Mar. 17, 2014.)

Amendment Notes — The 2012 amendment added the last paragraph.

The 2014 amendment added the last two sentences in the first paragraph and deleted the last paragraph, which read "Further, the commissioner may appoint or employ special counsel pursuant to the provisions of Section 7-5-39."

§ 83-1-35. Reward in case of willful destruction by fire or explosion of real or personal property within state.

The Commissioner of Insurance is hereby authorized, in his discretion, to offer a reward not to exceed Five Thousand Dollars ($5,000.00) for information leading to the apprehension, indictment and conviction of any person, persons or organization of persons responsible for the willful destruction by fire or explosion of any real or personal property located within this state.

The Commissioner of Insurance is further directed to have suitable reward notices printed and posted in conspicuous places, and to utilize such other news media or informational materials as necessary to encourage those with information to come forward.

The reward monies paid, if any, as well as the cost of printing and distribution of reward notices and other news media or informational materials, shall be paid from premium taxes under Sections 27-15-103 and 27-15-109. However, the Commissioner of Insurance shall keep a separate account of all monies disbursed under the provisions of this section and shall include the same in his annual report.

SOURCES: Codes, 1942, § 5630.5; Laws, 1958, ch. 447, §§ 1-3; Laws, 1979, ch. 316; Laws, 1982, ch. 351, § 14; reenacted, Laws, 1982, ch. 366, § 16; reenacted, Laws, 1990, ch. 559, § 19; reenacted without change, Laws, 1996, ch. 313, § 18; Laws, 2013, ch. 324, § 1, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment substituted "Five Thousand Dollars ($5,000.00)" for "One Thousand Dollars ($1,000.00)" in the first paragraph.

COMPREHENSIVE HURRICANE DAMAGE MITIGATION PROGRAM

SEC.

83-1-191. Comprehensive hurricane damage mitigation program established; cost-benefit study on wind hazard mitigation construction measures; inspections; financial grants for residential retrofits; public education; advisory council; rules and regulations [Repealed effective July 1, 2015].

§ 83-1-191. Comprehensive hurricane damage mitigation program established; cost-benefit study on wind hazard mitigation construction measures; inspections; financial grants for residential retrofits; public education; advisory council; rules and regulations [Repealed effective July 1, 2015].

(1) There is established within the Department of Insurance a Comprehensive Hurricane Damage Mitigation Program. This section does not create an entitlement for property owners or obligate the state in any way to fund the inspection or retrofitting of residential property or commercial property in this state. Implementation of this program is subject to the availability of funds that may be appropriated by the Legislature for this purpose. The program may develop and implement a comprehensive and coordinated approach for hurricane damage mitigation that may include the following:

(a) **Cost-benefit study on wind hazard mitigation construction measures.** — The performance of a cost-benefit study to establish the most appropriate wind hazard mitigation construction measures for both new construction and the retrofitting of existing construction for both residential and commercial facilities within the wind-borne debris regions of Mississippi as defined by the International Building Code. The recommended wind construction techniques shall be based on both the newly adopted Mississippi building code sections for wind load design and the wind-borne debris region. The list of construction measures to be considered for evaluation in the cost-benefit study shall be based on scientifically established and sound, but common, construction techniques that go above and beyond the basic recommendations in the adopted building codes. This allows residents to utilize multiple options that will further reduce risk and loss and still be awarded for their endeavors with appropriate wind insurance discounts. It is recommended that existing accepted scientific studies that validate the wind hazard construction techniques benefits and effects be taken into consideration when establishing the list of construction techniques that homeowners and business owners can employ. This will ensure that only established construction measures that have been studied and modeled as successful mitigation measures will be considered to reduce the chance of including risky or unsound data that will cost both the property owner and state unnecessary losses. The cost-benefit study shall be based on actual construction cost data collected for several types of residential construction and commercial construction materials, building techniques and designs that are common to the region. The study shall provide as much information as possible that will enhance the data and options provided to the public, so that homeowners and business owners can make informed and educated decisions as to their level of involvement. Based on the construction data, modeling shall be performed on a variety of residential and commercial designs, so that a broad enough representative spectrum of data can be obtained. The data from the study will be utilized in a report to establish

tables reflecting actuarially appropriate levels of wind insurance discounts (in percentages) for each mitigation construction technique/combination of techniques. This report will be utilized as a guide for the Department of Insurance and the insurance industry for developing actuarially appropriate discounts, credits or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. Additional data that will enhance the program, such as studies to reflect property value increases for retrofitting or building to the established wind hazard mitigation construction techniques and cost comparison data collected to establish the value of this program against the investment required to include the mitigation measures, also may be provided.

(b) **Wind certification and hurricane mitigation inspections.**

(i) Home-retrofit inspections of site-built, residential property, including single-family, two-family, three-family or four-family residential units, and a set of representative commercial facilities may be offered to determine what mitigation measures are needed and what improvements to existing residential properties are needed to reduce the property's vulnerability to hurricane damage. A state program may be established within the Department of Insurance to provide homeowners and business owners wind certification and hurricane mitigation inspections. The inspections provided to homeowners and business owners, at a minimum, must include:

1. A home inspection and report that summarizes the results and identifies corrective actions a homeowner may take to mitigate hurricane damage.

2. A range of cost estimates regarding the mitigation features.

3. Insurer-specific information regarding premium discounts correlated to recommended mitigation features identified by the inspection.

4. A hurricane resistance rating scale specifying the home's current as well as projected wind resistance capabilities.

This data may be provided by trained and certified inspectors in standardized reporting formats and forms to ensure all data collected during inspections is equivalent in style and content that allows construction data, estimates and discount information to be easily assimilated into a database. Data pertaining to the number of inspections and inspection reports may be stored in a state database for evaluation of the program's success and review of state goals in reducing wind hazard loss in the state.

(ii) To qualify for selection by the department as a provider of wind certification and hurricane mitigation inspections services, the entity shall, at a minimum, and on a form and in the manner prescribed by the commissioner:

1. Use wind certification and hurricane mitigation inspectors who:

a. Have prior experience in residential and/or commercial construction or inspection and have received specialized training in

hurricane mitigation procedures through the state certified program. In order to qualify for training in the inspection process, the individual should be either a licensed building code official, a licensed contractor or inspector in the State of Mississippi, or a civil engineer.

b. Have undergone drug testing and background checks.

c. Have been certified through a state mandated training program, in a manner satisfactory to the department, to conduct the inspections.

d. Have not been convicted of a felony crime of violence or of a sexual offense; have not received a first-time offender pardon or nonadjudication order for a felony crime of violence or of a sexual offense; or have not entered a plea of guilty or nolo contendere to a felony charge of violence or of a sexual offense.

e. Submit a statement authorizing the Commissioner of Insurance to order fingerprint analysis or any other analysis or documents deemed necessary by the commissioner for the purpose of verifying the criminal history of the individual. The commissioner shall have the authority to conduct criminal history verification on a local, state or national level, and shall have the authority to require the individual to pay for the costs of such criminal history verification.

2. Provide a quality assurance program including a reinspection component.

3. Have data collection equipment and computer systems, so that data can be submitted electronically to the state's database of inspection reports, insurance certificates, and other industry information related to this program. It is mandatory that all inspectors provide original copies to the property owner of any inspection reports, estimates, etc., pertaining to the inspection and keep a copy of all inspection materials on hand for state audits.

(c) **Financial grants to retrofit properties.** — Financial grants may be used to encourage single-family, site-built, owner-occupied, residential property owners or commercial property owners to retrofit their properties to make them less vulnerable to hurricane damage.

(d) **Education and consumer awareness.** — Multimedia public education, awareness and advertising efforts designed to specifically address mitigation techniques may be employed, as well as a component to support ongoing consumer resources and referral services. In addition, all insurance companies shall provide notification to their clients regarding the availability of this program, participation details, and directions to the state website promoting the program, along with appropriate contact phone numbers to the state agency administrating the program. The notification to the clients must be sent by the insurance company within thirty (30) days after filing their insurance discount schedules with the Department of Insurance.

(e) **Advisory council.** — There is created an advisory council to provide advice and assistance to the program administrator with regard to his or her administration of the program. The advisory council shall consist of:

(i) An agent, selected by the Independent Insurance Agents of Mississippi.

(ii) Two (2) representatives of residential property insurers, selected by the Department of Insurance.

(iii) One (1) representative of homebuilders, selected by the Home Builders Association of Mississippi.

(iv) The Chairman of the House Insurance Committee, or his designee.

(v) The Chairman of the Senate Insurance Committee, or his designee.

(vi) The Executive Director of the Mississippi Windstorm Underwriting Association, or his designee.

(vii) The Director of the Mississippi Emergency Management Agency, or his designee.

Members appointed under subparagraphs (i) and (ii) shall serve at the pleasure of the Department of Insurance. All other members shall serve as voting ex officio members. Members of the advisory council who are not legislators, state officials or state employees shall be compensated at the per diem rate authorized by Section 25-3-69, and shall be reimbursed in accordance with Section 25-3-41, for mileage and actual expenses incurred in the performance of their duties. Legislative members of the advisory council shall be paid from the contingent expense funds of their respective houses in the same manner as provided for committee meetings when the Legislature is not in session; however, no per diem or expense for attending meetings of the advisory council may be paid while the Legislature is in session. No advisory council member may incur per diem, travel or other expenses unless previously authorized by vote, at a meeting of the council, which action shall be recorded in the official minutes of the meeting. Nonlegislative members shall be paid from any funds made available to the advisory council for that purpose.

(f) **Rules and regulations.** — The Department of Insurance may adopt rules and regulations governing the Comprehensive Hurricane Damage Mitigation Program. The department also may adopt rules and regulations establishing priorities for grants provided under this section based on objective criteria that gives priority to reducing the state's probable maximum loss from hurricanes. However, pursuant to this overall goal, the department may further establish priorities based on the insured value of the dwelling, whether or not the dwelling is insured by the Mississippi Windstorm Underwriting Association and whether or not the area under consideration has sufficient resources and the ability to perform the retrofitting required.

(2) Nothing in this section shall prohibit the Department of Insurance from entering into an agreement with any other appropriate state agency to assist with or perform any of the duties set forth hereunder.

(3) This section shall stand repealed from and after July 1, 2015.

SOURCES: Laws, 2007, ch. 524, § 4; Laws, 2009, ch. 537, § 1; Laws, 2010, ch. 313, § 1; Laws, 2012, ch. 307, § 1, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment extended the repealer provision in (3), from "July 1, 2012" to "July 1, 2015."

Cross References — State agencies and public officials providing information about the agency or office to the public on a website are required to regularly review and update that information, see § 25-1-117.

CHAPTER 2

Competitive Rating for Property and Casualty Insurance

SEC.

83-2-3. Standards applicable to rates; criteria for determining compliance; commissioner to establish uniform policy language regarding applicability of hurricane deductibles and form of notice under certain homeowner's insurance policies.

§ 83-2-3. Standards applicable to rates; criteria for determining compliance; commissioner to establish uniform policy language regarding applicability of hurricane deductibles and form of notice under certain homeowner's insurance policies.

(1) Rates shall comply with the following standards:

(a) Rates shall not be excessive, inadequate or unfairly discriminatory.

(b) A rate is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if the expense provision included therein is unreasonably high in relation to the services rendered.

(c) A rate is inadequate if it threatens the solvency of the insurance company or tends to create a monopoly.

(d) Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with like loss exposures with different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

(2) In determining whether rates comply with the standards set forth in subsection (1), the following criteria shall apply:

(a) Due consideration shall be given to past and prospective loss and expense experience within and outside this state; to catastrophe hazards; to any residual market loss redistributions and other similar obligations; to a reasonable provision for profit and contingencies; to trends within and outside this state; to loadings for leveling premium rates over a reasonable period of time or for dividends or savings to be allowed or returned by insurers to their policyholders, members or subscribers; and to all other relevant factors, including the judgment of the filer.

(b) Risks may be classified in any reasonable way for the establishment of rates except that no risks may be grouped by classifications based, in whole or in part, on race, color, creed, or national origin of the risk. Rates may be modified for individual risks in accordance with rating plans or schedules which provide for recognition of probable variations in hazards, expenses or both.

(c) The systems of expense provisions included in rates for use by an insurer or group of insurers may differ from those of other insurers or group of insurers to reflect the operating methods of such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.

(d) Any homeowners' insurance policy filed with the Commissioner of Insurance that offers a percentage deductible for the peril of windstorm from a named storm shall offer a buy-back provision for that deductible which is actuarially sound; however, the Commissioner of Insurance may grant a waiver from the mandatory buy-back provision in accordance with the following procedure and criteria:

(i) An insurance company shall make a formal filing requesting a waiver from the buy-back provision requirement with the Commissioner of Insurance.

(ii) An insurance company shall submit written proof in its formal filing as to why it is in the best interest of Mississippi policyholders to receive a waiver from the buy-back provision requirement and shall provide any supporting documentation requested by the commissioner deemed appropriate to make his decision.

(iii) All expenses incurred by the Commissioner of Insurance or his designee in determining the validity of the waiver request shall be borne by the petitioning insurer. Such expenses may include, but not be limited to, the cost of reviewing the filing by actuaries, and if the commissioner deems a public hearing appropriate, the cost of a facility, the cost of publicity and the cost of a court reporter for the hearing.

(e) The commissioner shall establish by regulation uniform policy language regarding the applicability of hurricane deductibles and the form of notice to be provided to an insured under a homeowner's insurance policy by an insurer utilizing a hurricane deductible program or programs. The term "hurricane," for the purpose of a hurricane deductible program, means a storm system that has been declared to be a hurricane by the National Hurricane Center of the National Weather Service. The duration of the hurricane includes the time period, in Mississippi:

(i) Beginning at the time a hurricane watch or hurricane warning is issued for any part of Mississippi by the National Hurricane Center of the National Weather Service;

(ii) Continuing for the time period during which the hurricane conditions exist anywhere in Mississippi; and

(iii) Ending twenty-four (24) hours following the termination of the last hurricane watch or hurricane warning issued for any part of Mississippi by the National Hurricane Center of the National Weather Service.

SOURCES: Laws, 1987, ch. 422, § 3; Laws, 1999, ch. 468, § 1; Laws, 2014, ch. 380, § 1, eff from and after July 1, 2014.

Amendment Notes — The 2014 amendment added (2)(e) and made minor punctuation changes.

JUDICIAL DECISIONS

1. Private cause of action.

Miss. Code Ann. § 83-2-3 was regulatory in nature and afforded no private right of action; the Mississippi Commissioner of Insurance was charged with enforcement of § 83-2-3. Miss. Code Ann. § 83-2-29(1). The defendant correctly stated that the plaintiff confessed the excessive rate standards claim, and the parties agreed that no private cause of action existed under Miss. Code Ann. § 83-2-3; therefore, the court granted summary judgment in favor of the defendant as to the plaintiff's excessive rate standards claim. Mullen v. Nationwide Mut. Ins. Co., — F. Supp. 2d —, 2013 U.S. Dist. LEXIS 7679 (S.D. Miss. Jan. 18, 2013).

§ 83-2-29. Penalties; procedures for license suspension.

JUDICIAL DECISIONS

1. Enforcement.

Miss. Code Ann. § 83-2-3 was regulatory in nature and afforded no private right of action; the Mississippi Commissioner of Insurance was charged with enforcement of § 83-2-3. Miss. Code Ann. § 83-2-29(1). The defendant correctly stated that the plaintiff confessed the excessive rate standards claim, and the parties agreed that no private cause of action existed under Miss. Code Ann. § 83-2-3; therefore, the court granted summary judgment in favor of the defendant as to the plaintiff's excessive rate standards claim. Mullen v. Nationwide Mut. Ins. Co., — F. Supp. 2d —, 2013 U.S. Dist. LEXIS 7679 (S.D. Miss. Jan. 18, 2013).

CHAPTER 3

Commissioner of Insurance, Rating Bureau and Rates

ARTICLE 1.

COMMISSIONER OF INSURANCE AND RATING BUREAU.

§ 83-3-24. Factors to be considered when rating fire district, grading fire departments and awarding credits considered in determining overall fire rating based on condition of certain fire equipment.

Cross References — State agencies and public officials providing information about the agency or office to the public on a website are required to regularly review and update that information, see § 25-1-117.

CHAPTER 5

General Provisions Relative to Insurance and Insurance Companies

Periodic Financial Examinations of Insurers 83-5-201
Risk-Based Capital Level Requirements 83-5-401
Property and Casualty Actuarial Opinion Act 83-5-501

PERIODIC FINANCIAL EXAMINATIONS OF INSURERS

SEC.
83-5-205. Examination of insurers; examination of foreign or alien insurer; acceptance of examination report prepared by insurance department of another state; financial and market analysis review of all insurers.
83-5-209. Contents of examination report; filing of report; opportunity to respond to report; review of report by and order of commissioner; hearings; confidentiality of examination reports; disclosure of reports.

§ 83-5-205. Examination of insurers; examination of foreign or alien insurer; acceptance of examination report prepared by insurance department of another state; financial and market analysis review of all insurers.

(1) The commissioner or any of his examiners may conduct an examination under Sections 83-5-201 through 83-5-217 of any company as often as the commissioner, in his or her sole discretion, deems appropriate but, at a minimum, shall conduct an examination of every insurer licensed in this state not less frequently than once every five (5) years. In scheduling and determining the nature, scope and frequency of the examinations, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners and in effect when the commissioner exercises discretion under this section.

(2) For purposes of completing an examination of any company under Sections 83-5-201 through 83-5-217, the commissioner may examine or investigate any person, or the business of any person, insofar as such examination or investigation, in the sole discretion of the commissioner, is necessary or material to the examination of the company.

(3) In lieu of an examination under Sections 83-5-201 through 83-5-217 of any foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, such reports may only be accepted if (a) the insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or (b) the examination is performed under the super-

vision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(4) In addition to those examinations performed by the commissioner pursuant to subsection (1) of this section, the commissioner shall conduct financial and market analysis review of all insurers authorized to do business in this state and may conduct regulatory review of entities regulated by the department. The reviews may include the annual statement and the market conduct annual statement of the insurer or regulated entity reviewed, company financial reports rendered pursuant to good and acceptable accounting practices, results of insurance solvency standards testing as performed by the National Association of Insurance Commissioners, results of prior examinations and office reviews, management changes, consumer complaints, and such other relevant information as from time to time may be required by the commissioner.

(5) In lieu of conducting a financial or market analysis under this section of any foreign or alien insurer licensed in this state, the commissioner may rely upon the financial or market analysis conducted by the insurance department of the company's state of domicile or port-of-entry accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program.

(6) Every insurer or regulated entity shall produce and make freely accessible to the commissioner the accounts, records, documents and files in its possession or control. Failure by an insurer or regulated entity to supply information requested by the department during a course of financial or market analysis may subject the insurer or regulated entity to revocation or suspension of its license, or, in lieu thereof, a fine not to exceed Ten Thousand Dollars ($10,000.00) per occurrence.

SOURCES: Laws, 1992, ch. 319, § 3; Laws, 2012, ch. 364, § 1; Laws, 2013, ch. 416, § 1, eff from and after July 1, 2014.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2012 amendment substituted "five (5)" for "three (3)" at the end of the first sentence of (1).

The 2013 amendment, effective July 1, 2014, added (4) through (6).

§ 83-5-209. Contents of examination report; filing of report; opportunity to respond to report; review of report by and order of commissioner; hearings; confidentiality of examination reports; disclosure of reports.

(1) All examination reports shall be comprised of only facts appearing upon the books, records or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2) No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) Within thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of examiner work papers and enter an order:

(a) Adopting the examination report as filed, or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violation; or

(b) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information and refiling in accordance with subsections (1) and (2) of this section; or

(c) Calling for an investigatory hearing with no less than twenty (20) days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

(4) All orders entered in accordance with subsection (3)(a) of this section shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner work papers, and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed under the Mississippi Administrative Procedures Act and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(5) Any hearing conducted under subsection (3)(c) of this section by the commissioner or authorized representative shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the

resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant work papers or by the written submission or rebuttal of the company. Within twenty (20) days of the conclusion of any such hearing, the commissioner shall enter an order in accordance with subsection (3)(a) of this section.

(a) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to examiner work papers which tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or his representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the department, the company or other persons. The documents produced shall be included in the record, and testimony taken by the commissioner or his representative shall be under oath and preserved for the record.

Nothing contained in this section shall require the department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(b) The hearing shall proceed with the commissioner or his representative posing questions to the persons subpoenaed. Thereafter, the company and the department may present testimony relevant to the investigation. Cross-examination shall be conducted only by the commissioner or his representative. The company and the department shall be permitted to make closing statements and may be represented by counsel of their choice.

(6)(a) Upon the adoption of the examination report under subsection (3)(a) of this section, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of ten (10) days except to the extent provided in subsection (2) of this section. Thereafter, the commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

(b) Nothing contained in Sections 83-5-201 through 83-5-217 shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with Sections 83-5-201 through 83-5-217.

(c) If the commissioner determines that regulatory action is appropriate as a result of any examination, he may initiate any proceedings or actions as provided by law.

(7)(a)(i) Except as provided in subsection (6) and in this subsection (7), documents, materials or other information, including, but not limited to,

all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under Sections 83-5-201 through 83-5-217, or in the course of analysis by the commissioner of the financial condition or market conduct of a company, shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(ii) Documents, materials or other information, including, but not limited to, all working papers, and copies thereof, in the possession or control of the National Association of Insurance Commissioners and its affiliates and subsidiaries shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action, if they are:

1. Created, produced or obtained by or disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries in the course of the National Association of Insurance Commissioners and its affiliates and subsidiaries assisting an examination made under Sections 83-5-201 through 83-5-217, or the laws of another state or jurisdiction that is substantially similar to Sections 83-5-201 through 83-5-217, or assisting a commissioner in the analysis of the financial condition or market conduct of a company; or

2. Disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries under paragraph (c) of this subsection by a commissioner.

(b) Neither the commissioner nor any person who received the documents, material or other information while acting under the authority of the commissioner, including the National Association of Insurance Commissioners and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials or information subject to paragraph (a) of this subsection.

(c) In order to assist in the performance of the commissioner's duties, the commissioner:

(i) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph (a) of this subsection, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication or other information;

(ii) May receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials

or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(iii) May enter into agreements governing the sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in paragraph (c) of this subsection.

(e) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

(f) For the purposes of this subsection, the terms "department," "insurance department," "law enforcement agency," "regulatory agency," and the "National Association of Insurance Commissioners" include, but are not limited to, their employees, agents, consultants and contractors.

SOURCES: Laws, 1992, ch. 319, § 5; Laws, 2013, ch. 416, § 2, eff from and after July 1, 2014.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment, effective July 1, 2014, rewrote (7), which read: "All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under Sections 83-5-201 through 83-5-217 may be held by the commissioner as a record not required to be made public under the Mississippi Public Records Act."

RISK-BASED CAPITAL LEVEL REQUIREMENTS

SEC.

83-5-401. Definitions.

83-5-403. Filing of RBC report; determination of insurer's RBC; maintenance of capital above prescribed RBC level; adjustment of report.

83-5-405. Procedure upon occurrence of company action level event.

83-5-417. Relationship with other laws; promulgation of rules and regulations; exemption of domestic insurers and domestic health organization insurers.

83-5-427. Requirements for RBC reports for certain insurers for 1996; requirements for RBC reports for health organization insurers for 2013.

§ 83-5-401. Definitions.

As used in Sections 83-5-401 through 83-5-427, the following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Adjusted RBC report" means a risk-based capital report which has been adjusted by the commissioner in accordance with Section 83-5-403(5).

(b) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

(c) "Domestic insurer" means any insurance company domiciled in this state.

(d) "Foreign insurer" means any insurance company which is licensed to do business in this state under Section 83-21-1 et seq., but is not domiciled in this state.

(e) "NAIC" means the National Association of Insurance Commissioners.

(f) "Life and/or health insurer" means any insurance company licensed under Section 83-19-1 et seq., or a licensed property and casualty insurer writing only accident and health insurance.

(g) "Property and casualty insurer" means any insurance company licensed under Section 83-19-1 et seq., but shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers.

(h) "Negative trend" means, with respect to a life and/or health insurer, negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the Life RBC instructions.

(i) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(j) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(i) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(ii) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(iii) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(iv) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(k) "RBC plan" means a comprehensive financial plan containing the elements specified in Section 83-5-405(2). If the commissioner rejects the RBC plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

(*l*) "RBC report" means the report required in Section 83-5-403.

(m) "Total adjusted capital" means the sum of:

(i) An insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under Section 83-5-55; and

(ii) Such other items, if any, as the RBC instructions may provide.

(n) "Domestic health organization insurer" means a health organization insurer domiciled in this state.

(o) "Foreign health organization insurer" means a health organization insurer that is licensed to do business in this state under Section 83-21-1 et seq., but is not domiciled in this state.

(p) "Health organization insurer" means a health maintenance organization, limited health service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization that holds a certificate of authority under Section 83-41-305. This definition does not include an organization that is licensed as either a life and health insurer or property and casualty insurer and that is otherwise subject to either the life or property and casualty RBC requirements.

SOURCES: Laws, 1996, ch. 478, § 1; Laws, 2010, ch. 340, § 1; Laws, 2013, ch. 416, § 3, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment added (n) through (p).

§ 83-5-403. Filing of RBC report; determination of insurer's RBC; maintenance of capital above prescribed RBC level; adjustment of report.

(1) Every domestic insurer shall, on or before each March 1, the filing date, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

(ii) The filing date.

(2) A life and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into

account, and may adjust for the covariance between, the following factors determined in each case by applying the factors in the manner set forth in the RBC instructions.

(a) The risk with respect to the insurer's assets;

(b) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) The interest rate risk with respect to the insurer's business; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(3) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account, and may adjust for the covariance between, determined in each case by applying the factors in the manner set forth in the RBC instructions:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(4) A health organization insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(5) An excess of capital over the amount produced by the risk-based capital requirements contained in Sections 83-5-401 through 83-5-427 and the formulas, schedules and instructions referenced in Sections 83-5-401 through 83-5-427, is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by Sections 83-5-401 through 83-5-427. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in Sections 83-5-401 through 83-5-427.

(6) If a domestic insurer files a RBC report which in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. A RBC report as so adjusted is referred to as an "adjusted RBC report."

SOURCES: Laws, 1996, ch. 478, § 2; Laws, 2010, ch. 340, § 2; Laws, 2013, ch. 416, § 4, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment added (4) and renumbered former (4) and (5) as (5) and (6).

§ 83-5-405. Procedure upon occurrence of company action level event.

(1) "Company action level event" means any of the following events:

(a) The filing of a RBC report by an insurer which indicates that:

(i) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) If a life and/or health insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 2.5 and has a negative trend; or

(iii) If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions;

(iv) If a health organization insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculations included in the health RBC instructions;

(b) The notification by the commissioner to the insurer of an adjusted RBC report that indicates an event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under Section 83-5-413; or

(c) If, under Section 83-5-413, an insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the commissioner a RBC plan which shall:

(a) Identify the conditions which contribute to the company action level event;

(b) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(c) Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of

proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(3) The RBC plan shall be submitted:

(a) Within forty-five (45) days of the company action level event; or

(b) If the insurer challenges an adjusted RBC report under Section 83-5-413, within forty-five (45) days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within sixty (60) days after the submission by an insurer of a RBC plan to the commissioner, the commissioner shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) Within forty-five (45) days after the notification from the commissioner; or

(b) If the insurer challenges the notification from the commissioner under Section 83-5-413, within forty-five (45) days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(5) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under Section 83-5-413, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic insurer that files a RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) Such state has a RBC provision substantially similar to Section 83-5-415(1); and

(b) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(ii) The date on which the RBC plan or revised RBC plan is filed under Section 83-5-405(3) and (4).

SOURCES: Laws, 1996, ch. 478, § 3; Laws, 2010, ch. 340, § 3; Laws, 2013, ch. 416, § 5, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment added (1)(a)(iv).

§ 83-5-417. Relationship with other laws; promulgation of rules and regulations; exemption of domestic insurers and domestic health organization insurers.

(1) The provisions of Sections 83-5-401 through 83-5-427 are supplemental to any other provisions of the laws of this state and shall not preclude or limit any other powers or duties of the commissioner under such laws.

(2) The commissioner may promulgate rules and regulations necessary for the implementation of Sections 83-5-401 through 83-5-427.

(3) The commissioner may exempt from the application of Sections 83-5-401 through 83-5-427 any domestic insurer, other than a domestic health organization insurer, that:

(a) Writes direct business only in this state;

(b) Writes direct annual premiums of Two Million Dollars ($2,000,000.00) or less; and

(c) Assumes no reinsurance in excess of five percent (5%) of direct premium written.

(4) The commissioner may exempt from the application of Sections 83-5-401 through 83-5-427 a domestic health organization insurer that:

(a) Writes direct business only in this state;

(b) Assumes no reinsurance in excess of five percent (5%) of direct premium written; and

(c) Writes direct annual premiums for comprehensive medical business of Two Million Dollars ($2,000,000.00) or less, or is a limited health service organization that covers less than two thousand (2,000) lives.

SOURCES: Laws, 1996, ch. 478, § 9; Laws, 2013, ch. 416, § 6, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment inserted "other than a domestic health organization insurer," following "any domestic insurer" in the first paragraph of (3); and added (4).

§ 83-5-427. Requirements for RBC reports for certain insurers for 1996; requirements for RBC reports for health organization insurers for 2013.

(1) For RBC reports required to be filed by life insurers with respect to 1996, the following requirements shall apply in lieu of the provisions of Sections 83-5-405, 83-5-407, 83-5-409, and 83-5-411.

(a) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(b) In the event of a regulatory action level event under Section 83-5-407(1)(a), (b) or (c), the commissioner shall take the actions required under Section 83-5-405.

(c) In the event of a regulatory action level event under Section 83-5-407(1) (d), (e), (f), (g), (h) or (i), or an authorized control level event, the commissioner shall take the actions required under Section 83-5-407 with respect to the insurer.

(d) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under Section 83-5-409 with respect to the insurer.

(2) For RBC reports required to be filed by property and casualty insurers with respect to 1996, the following requirements shall apply in lieu of the provisions of Sections 83-5-405, 83-5-407, 83-5-409, and 83-5-411:

(a) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(b) In the event of a regulatory action level event under Section 83-5-407(1) (a), (b) or (c), the commissioner shall take the actions required under Section 83-5-405.

(c) In the event of a regulatory action level event under Section 83-5-407(1) (d), (e), (f), (g), (h) or (i), or an authorized control level event, the commissioner shall take the actions required under Section 83-5-407 with respect to the insurer.

(d) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under Section 83-5-409 with respect to the insurer.

(3) For RBC reports required to be filed by health organization insurers with respect to 2013, the following requirements shall apply in lieu of the provisions of Sections 83-5-405, 83-5-407, 83-5-409 and 83-5-411:

(a) In the event of a company action level event with respect to a domestic health organization insurer, the commissioner shall take no regulatory action hereunder;

(b) In the event of a regulatory action level event under Section 83-5-407(1) (a), (b) or (c), the commissioner shall take the actions required under Section 83-5-405;

(c) In the event of a regulatory action level event under Section 83-5-407(1)(d), (e), (f), (g), (h) or (i), or an authorized control level event, the commissioner shall take the actions required under Section 83-5-407 with respect to the health organization insurer; and

(d) In the event of a mandatory control level event with respect to a health organization insurer, the commissioner shall take the actions required under Section 83-5-409 with respect to the health organization insurer.

SOURCES: Laws, 1996, ch. 478, § 14; Laws, 2013, ch. 416, § 7, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment added (3).

PROPERTY AND CASUALTY ACTUARIAL OPINION ACT

SEC.

83-5-507. Repealed.

§ 83-5-501. Title.

SOURCES: Laws, 2009, ch. 441, § 1; reenacted without change, Laws, 2012, ch. 306, § 1, eff from and after July 1, 2012.

Editor's Note — This section was reenacted without change by Laws of 2012, ch. 306, effective from and after July 1, 2012. Since the language of the section as it appears in the main volume is unaffected by the reenactment, it is not reprinted in this supplement.

Amendment Notes — The 2012 amendment reenacted the section without change.

§ 83-5-503. Actuarial opinion of reserves and supporting documentation.

SOURCES: Laws, 2009, ch. 441, § 2; reenacted without change, Laws, 2012, ch. 306, § 2, eff from and after July 1, 2012.

Editor's Note — This section was reenacted without change by Laws of 2012, ch. 306, effective from and after July 1, 2012. Since the language of the section as it appears in the main volume is unaffected by the reenactment, it is not reprinted in this supplement.

Amendment Notes — The 2012 amendment reenacted the section without change.

§ 83-5-505. Confidentiality.

SOURCES: Laws, 2009, ch. 441, § 3; reenacted without change, Laws, 2012, ch. 306, § 3, eff from and after July 1, 2012.

Editor's Note — This section was reenacted without change by Laws of 2012, ch. 306, effective from and after July 1, 2012. Since the language of the section as it appears in the main volume is unaffected by the reenactment, it is not reprinted in this supplement.

Amendment Notes — The 2012 amendment reenacted the section without change.

§ 83-5-507. Repealed.

Repealed by Laws of 2012, ch. 306, § 4, effective July 1, 2012.

§ 83-5-507. [Laws, 2009, ch. 441, § 4, eff from and after Jan. 1, 2010.]

Editor's Note — Former § 83-5-507 would have repealed §§ 83-5-501 through 83-5-507, effective July 1, 2012.

CHAPTER 6

Registration and Examination of Insurers

SEC.

83-6-1. Definitions.
83-6-5. Registration statement; filing, form and contents; annual enterprise risk report.
83-6-17. Disclaimer of affiliation; effect of filing; disallowance.
83-6-21. Standards for transactions within holding company system; notice to commissioner of certain intended transactions; action by commissioner against violators; stock company permits.
83-6-24. Filing of statement by person making offer, request, etc.; contents of statement; approval by commissioner; exceptions; violations of section; jurisdiction of courts.
83-6-26. Management of domestic insurers subject to registration.
83-6-27. Financial examination of registered insurer or affiliate.
83-6-29. Confidential treatment of information, materials or documents obtained or disclosed during certain examinations.

§ 83-6-1. Definitions.

As used in this chapter the following terms have the respective meanings herein set forth unless the context shall require otherwise:

(a) An "affiliate of" or person "affiliated" with a specific person means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Control" (including the terms "controlling," "controlled by" and "under common control with") means the possession of the power to direct or cause the direction of the management and policies of a person, whether

through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services or otherwise, unless the power is the result of an official position with or corporate office held by the person. "Control" shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided in Section 83-6-17 that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(d) An "insurance holding company system" consists of two (2) or more affiliated persons, one or more of which is an insurer.

(e) "Insurer" means only those companies subject to the jurisdiction of the commissioner as provided in Section 83-5-1; however, burial associations regulated pursuant to Chapter 37, Title 83, Mississippi Code of 1972, are excluded from this definition.

(f) "Person" means an individual, corporation, partnership, association, joint-stock company, trust, unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any securities broker performing no more than the usual and customary broker's function.

(g) A "security holder" of a specified person means one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

(h) "Subsidiary" of a specified person means an affiliate controlled by a person, directly or indirectly, through one or more intermediaries.

(i) The term "voting security" includes any security convertible into or evidencing a right to acquire a voting security.

(j) "Enterprise risk" shall mean any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's Risk-Based Capital to fall into company action level as provided in Section 83-5-405 or would cause the insurer to be in hazardous financial condition as provided in Section 83-5-411.

SOURCES: Laws, 1974, ch. 366, § 1; Laws, 1992, ch. 573, § 1; Laws, 1997, ch. 410, § 8; Laws, 2013, ch. 416, § 8, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment inserted "Mississippi Code of 1972" near the end of (e); added (j); and made a minor stylistic change.

§ 83-6-5. Registration statement; filing, form and contents; annual enterprise risk report.

(1) Every insurer subject to registration is required to file a registration statement on a form provided by the commissioner which shall contain current information setting forth:

(a) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

(b) The identity of every member of the insurance holding company system;

(c) The following agreements in force, relationships subsisting and transactions currently outstanding between such insurer and its affiliates:

(i) Loans, other investments or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) Purchases, sales or exchanges of assets;

(iii) Transactions not in the ordinary course of business;

(iv) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) All management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles;

(vi) Reinsurance agreements covering all or substantially all of one or more lines of insurance of the ceding company;

(vii) Dividends and other distributions to shareholders; and

(viii) Consolidated tax allocation agreements.

(d) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(e) If requested by the commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include, but are not limited to, annual audited financial statements filed with the United States Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;

(f) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner;

(g) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior

management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.

(2) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(3) Subject to Section 83-6-25, each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.

(4) Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this chapter.

(5) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

SOURCES: Laws, 1974, ch. 366, § 2(2); Laws, 2013, ch. 416, § 9, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment inserted the (1) designator at the beginning and added (1)(c)(vii), (viii), (1)(d), (e) and (g) and redesignated former (1)(d) as (1)(f); added (2) through (5); and made minor stylistic changes.

§ 83-6-17. Disclaimer of affiliation; effect of filing; disallowance.

Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party that the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party is relieved of any duty to register or report under this chapter which may arise out of the insurer's relationship with such person if approval of the disclaimer has been granted by the commissioner, until the commissioner disallows such a disclaimer.

SOURCES: Laws, 1974, ch. 366, § 2(9); Laws, 2013, ch. 416, § 10, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment rewrote the section.

§ 83-6-21. Standards for transactions within holding company system; notice to commissioner of certain intended transactions; action by commissioner against violators; stock company permits.

(1) Transactions within a holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Charges or fees for services performed shall be reasonable;

(c) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(d) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(e) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) The following transactions involving a domestic insurer and any person in its holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subsection (1)(a) through (e) of this section, shall not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into such transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within such period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported within thirty (30) days after a termination of a previously filed agreement to the commissioner for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans or extension of credit, guarantees or investments provided such transactions are equal to or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards

policyholders; and (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of December 31 next preceding:

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extension of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of or to make investments in, any affiliate of the insurer making such loans or extensions of credit provided such transactions are equal to or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; and (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of December 31 next preceding;

(c) Reinsurance agreements or modifications thereto, including (i) all reinsurance pooling agreements; and (ii) agreements in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of December 31 next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of such assets will be transferred to one or more affiliates of the insurer;

(d) All management agreements that would place control of the insurer outside of the insurance holding company system;

(e) All service contracts or cost-sharing arrangements wherein the annual aggregate cost to the insurer would equal or exceed the amounts specified in paragraph (a) of this subsection;

(f) All tax allocation agreements;

(g) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer's admitted assets or ten percent (10%) of surplus as regards policyholders as of December 31 next preceding. Further, all guarantees which are not quantifiable as to amounts are subject to the notice requirements of this paragraph;

(h) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer's surplus as to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 83-6-2, or in nonsubsidiary insurance affiliates that are subject to the provisions of this chapter, are exempt from this requirement; and

(i) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders.

(3) A domestic insurer shall not enter into transactions which are part of a plan or series of like transactions with persons within the holding company

system if the purpose of those separate transactions is to avoid the statutory threshold amount and avoid the review that would occur otherwise. If the commissioner determines that such separate transactions were entered into over any twelve-month period for such purpose, he may exercise his authority under Section 83-6-35.

(4) The commissioner, in reviewing transactions pursuant to subsection (2) of this section, shall consider whether the transactions comply with the standards set forth in subsection (1) of this section and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one (1) corporation if the total investment in such corporation by the insurance holding company system exceeds ten percent (10%) of such corporation's voting securities.

(6) Insurance companies within a holding company system shall not sell or exchange their stock among each other unless the companies have obtained stock company permits before conducting such transactions.

SOURCES: Laws, 1974, ch. 366, § 3(1); Laws, 1992, ch. 573, § 2; Laws, 1998, ch. 323, § 1; Laws, 2013, ch. 416, § 11, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment in (2), added language beginning "including amendments or modifications" and ending "through (e) of this section" in the first sentence, and added the last two sentences; added "including (i) all reinsurance pooling agreements; and (ii) agreements" following "Reinsurance agreements or modifications thereto" at the beginning of (2) (c); added (2)(f) through (i); and made minor stylistic changes throughout.

§ 83-6-24. Filing of statement by person making offer, request, etc.; contents of statement; approval by commissioner; exceptions; violations of section; jurisdiction of courts.

(1)(a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of such insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any such offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to such insurer, a statement containing the information required by this

section and such offer, request, invitation, agreement or acquisition has been approved by the commissioner in the manner hereinafter prescribed.

(b) For the purposes of this section, "a domestic insurer" shall include any person controlling a domestic insurer unless such person as determined by the commissioner is either directly or through its affiliates primarily engaged in business other than the business of insurance. However, such person shall file a preacquisition notification with the commissioner containing the information set forth in this section thirty (30) days prior to the proposed effective date of the acquisition. For the purposes of this section, "person" shall not include any securities broker holding, in the usual and customary brokers function, less than twenty percent (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

(c) For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least thirty (30) days prior to the cessation of control. The commissioner shall determine those instances in which the party(ies) seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his discretion, determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in paragraph (b) of this subsection is otherwise filed, this paragraph shall not apply.

(2) The statement to be filed with the commissioner hereunder shall be made under oath or affirmation and shall contain the following information:

(a) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (1) is to be effected (hereinafter called "acquiring party"), and

(i) If such person is an individual, his principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years;

(ii) If such person is not an individual, a report of the nature of its business operations during the past five (5) years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by subparagraph (i).

(b) The source, nature and amount of consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose (including any pledge of the insurer's stock, or the stock of any of its

subsidiaries or controlling affiliates), and the identity of persons furnishing such consideration, provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests.

(c) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each such acquiring party (or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence), and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement.

(d) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

(e) The number of shares of any security referred to in subsection (1) which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (1), and a statement as to the method by which the fairness of the proposal was determined.

(f) The amount of each class of any security referred to in subsection (1) which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(g) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (1) in which any acquiring party is involved, including but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

(h) A description of the purchase of any security referred to in subsection (1) during the twelve (12) calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid therefor.

(i) A description of any recommendations to purchase any security referred to in subsection (1) made during the twelve (12) calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

(j) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for and agreements to acquire or exchange any securities referred to in subsection (1) and (if distributed) of additional soliciting material relating thereto.

(k) The terms of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (1) for tender, and the amount of any fees,

commissions or other compensation to be paid to broker-dealers with regard thereto.

(*l*) An agreement by the person required to file the statement referred to in subsection (1) that it will provide the annual report, specified in Section 83-6-5(5), for so long as control exists.

(m) An acknowledgment by the person required to file the statement referred to in subsection (1) that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer.

(n) Such additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in subsection (1) is a partnership, limited partnership, syndicate or other group, the commissioner may require that the information called for by paragraphs (a) through (l) shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group and each person who controls such partner or member. If any such partner, member or person is a corporation, or the person required to file the statement referred to in subsection (1) is a corporation, the commissioner may require that the information called for by paragraphs (a) through (l) shall be given with respect to such corporation, each officer and director of such corporation and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of such corporation.

If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the commissioner and sent to such insurer within two (2) business days after the person learns of such change.

(3) If any offer, request, invitation, agreement or acquisition referred to in subsection (1) is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (1) may utilize such documents in furnishing the information called for by that statement.

(4)(a) The commissioner shall approve any merger or other acquisition of control referred to in subsection (1) unless, after a public hearing thereon, he finds that:

(i) After the change of control, the domestic insurer referred to in subsection (1) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(ii) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein;

(iii) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(iv) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(v) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(vi) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.

(b) The public hearing referred to in paragraph (a) of this subsection shall be commenced not less than thirty (30) days after the statement required by subsection (1) is filed, and at least twenty (20) days' notice thereof shall be given by the commissioner to the person filing the statement. Not less than seven (7) days' notice of such public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The commissioner shall make a determination within thirty (30) days after the conclusion of such hearing. At such hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.

(c) The commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

(d) If the proposed acquisition of control will require the approval of more than one (1) commissioner, the public hearing referred to in paragraph (a) of subsection (4) may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (1) of this section. Such person shall file the statement referred to in subsection (1) with the National Association of Insurance Commissioners (NAIC) within five (5) days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) days of the receipt of the statement referred to in subsection (1). A hearing conducted on a consolidated basis shall be public and shall be

held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing, in person or by telecommunication.

(e) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to Section 83-6-24(1).

(5) The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition which the commissioner by order shall exempt therefrom as (i) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or (ii) as otherwise not comprehended within the purposes of this section.

(6) The following shall be violations of this section:

(a) The failure to file any statement, amendment or other material required to be filed pursuant to subsection (1) or (2); or

(b) The effectuation or any attempt to effectuate an acquisition of control of, or merger with, a domestic insurer unless the commissioner has given his approval thereto.

(7) The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this state who files a statement with the commissioner under this section, and overall actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by such a person of the commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all such lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to such person at his last-known address.

SOURCES: Laws, 1992, ch. 573, § 5; Laws, 1997, ch. 410, § 9; Laws, 2013, ch. 416, § 12, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment in (1), inserted the (a) and (b) designations and added (c); added (2)(*l*) and (m) and redesignated former (2)(*l*) as (2)(n); added (4)(d) and (e); and made a minor stylistic change.

§ 83-6-26. Management of domestic insurers subject to registration.

(1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this section.

(2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of Section 83-6-21.

(3) Not less than one-third (⅓) of the directors of a domestic insurer, and not less than one-third (⅓) of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one (1) such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of subsections (3) and (4) shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of subsections (3) and (4) with respect to such controlling entity.

(6) An insurer may make application to the commissioner for a waiver from the requirements of this section, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than Three Hundred Million Dollars ($300,000,000.00). An insurer may also make application to the commissioner for a waiver from the requirements of this section based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

SOURCES: Laws, 2013, ch. 416, § 13, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

§ 83-6-27. Financial examination of registered insurer or affiliate.

(1) The commissioner is authorized to order any insurer registered under this chapter to produce such records, books, or other information papers in the possession of the insurer or its affiliates which are necessary to ascertain the financial condition or legality of conduct of such insurer. In the event such insurer fails to comply with such order, the commissioner is authorized to examine such affiliates to obtain such information.

(2) The commissioner shall exercise his authority under subsection (1) of this section only if the interests of the policyholders of such insurer may be adversely affected.

(3) The commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff which are reasonably necessary to assist in the conduct of the examination under subsection (1) of this section. Any persons so retained are under the direction and control of the commissioner and shall act in a purely advisory capacity.

(4) Each registered insurer producing for examination records, books and papers pursuant to subsection (1) of this section is liable for the expense of such examination.

SOURCES: Laws, 1974, ch. 366, § 4; Laws, 2001, ch. 379, § 1; Laws, 2013, ch. 416, § 14, eff from and after July 1, 2013.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment substituted "this chapter" for "Sections 83-6-3 through 83-6-19" in the first sentence of (1).

§ 83-6-29. Confidential treatment of information, materials or documents obtained or disclosed during certain examinations.

(1) Documents, materials or other information in the possession or control of the Department of Insurance that are obtained by or disclosed to the commissioner or any other person during an examination or investigation made pursuant to Section 83-6-27 and all information reported pursuant to Sections 83-6-24(2)(*l*) and (m), Sections 83-6-3, 83-6-5 and 83-6-21 shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the

commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

(2) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this section shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners (NAIC) and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.

(b) Notwithstanding paragraph (a) of this subsection, the commissioner may only share confidential and privileged documents, material or information reported pursuant to Section 83-6-5(5) with commissioners of states having statutes or regulations substantially similar to subsection (1) of this section and who have agreed in writing not to disclose such information.

(c) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(d) Shall enter into written agreements with the NAIC governing sharing and use of information provided pursuant to this section consistent with this subsection that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries pursuant to this section, including procedures and protocols

for sharing by the NAIC with other state, federal or international regulators;

(ii) Specify that ownership of information shared with the NAIC and its affiliates and subsidiaries pursuant to this section remains with the commissioner and the NAIC's use of the information is subject to the direction of the commissioner;

(iii) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC pursuant to this section is subject to a request or subpoena to the NAIC for disclosure or production; and

(iv) Require the NAIC and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC and its affiliates and subsidiaries pursuant to this section.

(4) The sharing of information by the commissioner pursuant to this section shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this section.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (3) of this section.

(6) Documents, materials or other information in the possession or control of the NAIC pursuant to this section shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

SOURCES: Laws, 1974, ch. 366, § 5; Laws, 2013, ch. 416, § 15, eff from and after July 1, 2014.

Editor's Note — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Amendment Notes — The 2013 amendment, effective July 1, 2014, rewrote the section, which read: "The commissioner, by rule, may designate for confidential treatment any information, documents and copies thereof obtained by or disclosed to himself or any other person in the course of an examination or investigation made pursuant to Section 83-6-27 and any information reported pursuant to Sections 83-6-3 through 83-6-19. Any information, document or copy so designated shall not be made public by the commissioner or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains."

Cross References — Mississippi Public Records Act, see §§ 25-61-1 et seq.

CHAPTER 7

Life Insurance

General Provisions 83-7-1
Unclaimed Life Insurance Benefits Act 83-7-301

GENERAL PROVISIONS

SEC.
83-7-23. Standard valuation law.
83-7-25. Standard nonforfeiture law.

§ 83-7-23. Standard valuation law.

(1) **Title and definitions:** (a) This section shall be known as the Standard Valuation Law.

(b) For the purposes of this section, the following definitions shall apply on or after the operative date of the valuation manual:

(i) The term "accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(ii) The term "appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection (3)(b) of this section.

(iii) The term "company" means an entity, which:

(A) Has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least one (1) such policy in force or on claim; or

(B) Has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state.

(iv) The term "deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(v) The term "life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(vi) The term "NAIC" means the National Association of Insurance Commissioners.

(vii) The term "policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this section, including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections pre-

scribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(viii) The term "principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection (12) of this section as specified in the valuation manual.

(ix) The term "qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(x) The term "tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(xi) The term "valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this section or as subsequently amended.

(2) **Reserve valuation:** — (a) Policies and contracts issued prior to the operative date of the valuation manual.

(i) The Insurance Commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state issued on or after April 14, 1948, and prior to the operative date of the valuation manual, except that, in the case of an alien company, such valuation shall be limited to its United States business. In calculating such reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves herein required of any foreign or alien company, the commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any other state or other jurisdiction when such other valuation complies with the minimum standard provided in this section.

(ii) The provisions set forth in subsections (3), (3-a), (3-b), (4), (4-a), (5), (6), (7), (8) and (10) of this section shall apply to all policies and contracts, as appropriate, subject to this section issued on or after April 14, 1948, and prior to the operative date of the valuation manual and the provisions set forth in subsections (11) and (12) of this section shall not apply to any such policies and contracts.

(iii) The minimum standard for the valuation of policies and contracts issued prior to April 14, 1948, shall be that provided by the laws in effect immediately prior to that date.

(b) Policies and contracts issued on or after the operative date of the valuation manual:

(i) The commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life

insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this section.

(ii) The provisions set forth in subsections (11) and (12) of this section shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

(3) **Computation of minimum standard:** — Except as otherwise provided in subsections (3-a) and (3-b) of this section the minimum standard for the valuation of all such policies and contracts issued before the operative date of Section 83-7-25 shall be that provided by the laws in effect immediately before such date.

Except as otherwise provided in subsections (3-a) and (3-b) of this section, the minimum standard for the valuation of all such policies and contracts issued on or after the operative date of Section 83-7-25 (the standard nonforfeiture law) shall be the commissioners reserve valuation methods defined in subsections (4), (4-a) and (7) of this section, three and one-half percent (3-½%) interest, or in the case of policies and contracts, other than annuity and pure endowment contracts, issued on or after September 1, 1975, four percent (4%) interest for such policies issued prior to January 1, 1980, five and one-half percent (5-½%) interest for single premium life insurance policies and four and one-half percent (4-½%) interest for all other such policies issued on and after January 1, 1980, and the following tables:

(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, — the Commissioners 1941 Standard Ordinary Mortality Table for such policies issued before the operative date of subsection (5-a) of Section 83-7-25 of the Standard Nonforfeiture Law for Life Insurance as amended; the Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after the operative date of subsection (5-a) of the Standard Nonforfeiture Law for Life Insurance as amended (Section 83-7-25(5-a)) and before the operative date of subsection (5-c) of the Standard Nonforfeiture Law for Life Insurance as amended (Section 83-7-25(5-c)), provided that for any category of such policies issued on female risks all modified net premiums and present values referred to in this section may be calculated according to an age not more than six (6) years younger than the actual age of the insured; and for such policies issued on or after the operative date of subsection (5-c) of the Standard Nonforfeiture Law for Life Insurance as amended (Section 83-7-25(5-c)):

(i) The Commissioners 1980 Standard Ordinary Mortality Table, or

(ii) At the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or

(iii) Any ordinary mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(b) For industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, — the 1941 Standard Industrial Mortality Table for such policies issued prior to the operative date of subsection (5-b) of Section 83-7-25, the Standard Nonforfeiture Law for Life Insurance as amended, and for such policies issued on or after such operative date the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table or, at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the commissioner.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951, any modification of such table approved by the commissioner, or, at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, — for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the NAIC, which are approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies — for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table.

Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis and other special benefits — such tables as may be approved by the commissioner.

(3-a) **Computation of minimum standard for annuities:** — (a) Except as provided in subsection (3-b), the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this subsection (3-a), as defined herein, and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioner's reserve valuation methods defined in subsections (4) and (4-a) of this section and the following tables and interest rates:

(i) For individual annuity and pure endowment contracts, issued before January 1, 1980, excluding any disability and accidental death benefits in such contracts, — the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the commissioner, and six percent (6%) interest for single premium immediate annuity contracts, and four percent (4%) interest for all other individual annuity and pure endowment contracts.

(ii) For individual single premium immediate annuity contracts issued on or after January 1, 1980, excluding any disability and accidental death benefits in such contracts, — the 1971 Individual Annuity Mortality Table, or any individual annuity mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and seven and one-half percent (7-½%) interest.

(iii) For individual annuity and pure endowment contracts issued on or after January 1, 1980, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any individual annuity mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and five and one-half percent (5-½%) interest for single premium deferred annuity and pure endowment contracts and four and one-half percent (4-½%) interest for all other such individual annuity and pure endowment contracts.

(iv) For all annuities and pure endowments purchased prior to January 1, 1980, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the commissioner, and six percent (6%) interest.

(v) For all annuities and pure endowments purchased on or after January 1, 1980, under group annuity and pure endowment contracts,

excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any group annuity mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half percent (7-½%) interest.

(b) After September 1, 1975, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this subsection (3-a) after a specified date before January 1, 1979, which shall be the operative date of this subsection for such insurer, provided an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1979.

(3-b) **Computation of minimum standard by calendar year of issue:** — (a) Applicability of this subsection. The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates as defined in this subsection:

(i) Life insurance policies issued in a particular calendar year, on or after the operative date of Section (5-c) of the Standard Nonforfeiture Law for Life Insurance (Section 83-7-25(5-c));

(ii) Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1984;

(iii) Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1984, under group annuity and pure endowment contracts; and

(iv) The net increase, if any, in a particular calendar year after January 1, 1984, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in this subsection.

(b) Calendar year statutory valuation interest rates.

(i) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of one percent (¼ of 1%):

(A) For life insurance,

I =.03 + W (R1 -.03) + W/2 (R2 -.09);

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

I =.03 + W (R -.03)

where R1 is the lesser of R and.09, R2 is the greater of R and.09, R is the reference interest rate defined in this section, and W is the weighting factor defined in this section;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in (B) above, the formula for life insurance stated in (A) above shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten (10) years and the formula for single premium immediate annuities stated in (B) above shall apply to annuities and guaranteed interest contracts with guarantee duration of ten (10) years or less;

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in (B) above shall apply;

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in (B) above shall apply.

(ii) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent (½ of 1%), the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when Section (5-c) of the Standard Nonforfeiture Law for Life Insurance (Section 83-7-25(5-c)) becomes operative.

(c) Weighting factors.

(i) The weighting factors referred to in the formulas stated above are given in the following tables:

(A) Weighting factors for life insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

.80

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in (B) above, shall be as specified in tables 1, 2 and 3 below, according to the rules and definitions in 4 and 5 below:

1. For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

2. For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in 1 above increased by:

Plan Type A	B	C
.15	.25	.05

3. For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one (1) year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve (12) months beyond the valuation date, the factors shown in 1 or derived in 2 increased by:

Plan Type A	B	C
.05	.05	.05

4. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty (20) years. For other annuities with no cash settle-

ment options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

5. Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five (5) years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only (1) with adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five (5) years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee funds may be withdrawn without such adjustment in a single sum or installments over less than five (5) years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five (5) years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(ii) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this subsection, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(d) Reference interest rate.

(i) The reference interest rate referred to in paragraph (b) of this subsection shall be defined as follows:

(A) For all life insurance, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year next preceding the year

of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or year of purchase of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in (B) above, with guarantee duration in excess of ten (10) years, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(D) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in (B) above, with guarantee duration of ten (10) years or less, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(E) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(F) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in (B) above, the average over a period of twelve (12) months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(e) Alternative method for determining reference interest rates.

In the event that the monthly average of the composite yield on seasoned corporate bonds, is no longer published by Moody's Investors Service, Inc., or in the event that the NAIC determines that the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by regulation promulgated by the commissioner, may be substituted.

(4) **Reserve valuation method-life insurance and endowment benefits:** — Except as otherwise provided in subsections (4-a) and (7), reserves according to the commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of (a) over (b), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one (1) per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one (1) year higher than the age at issue of such policy.

(b) A net one-year term premium for such benefits provided for in the first policy year.

Provided that for any life insurance policy issued on or after January 1, 1987, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection (7), be the greater of the reserve as of such policy anniversary calculated as described in the preceding paragraph and the reserve as of such policy anniversary calculated as described in that paragraph, but with (i) the value defined in subparagraph (a) of that paragraph being reduced by fifteen percent (15%) of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on such date as an endowment, and (iv) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in subsections (3-a) and (3-b) shall be used.

Reserves according to the commissioners reserve valuation method for: — (i) life insurance policies providing for a varying amount of

insurance or requiring the payment of varying premiums; (ii) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; (iii) disability and accidental death benefits in all policies and contracts; and (iv) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of the preceding paragraphs of this subsection.

(4-a) **Reserve valuation method-annuity and pure endowment benefits:** — This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.

Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

(5) **Minimum reserves:** — In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the operative date of the standard nonforfeiture law (Section 83-7-25), be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (4), (4-a), (7) and (8) and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(6) **Optional reserve calculation:** — Reserves for all policies and contracts issued prior to the effective date of Section 83-7-25 (the standard nonforfeiture law) may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to such date.

Reserves for any category of policies, contracts or benefits as established by the commissioner, issued on or after the operative date of Section 83-7-25 (the standard nonforfeiture law), may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in the policies or contracts.

Any company which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum herein provided.

(7) **Reserve calculation-valuation net premium exceeding the gross premium charges:** — If in any contract year the gross premium charged by any life insurance company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon, but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in subsections (3) and (3-b).

Provided that for any life insurance policy issued on or after January 1, 1987, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection (7) shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (4), ignoring the second paragraph of subsection (4). The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with subsection (4), including the second paragraph of that subsection, and the minimum reserve calculated in accordance with this subsection (7).

(8) **Reserve calculation-indeterminate premium plans:** — In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves

cannot be determined by the methods described in subsections (4), (4-a) and (7), the reserves which are held under any such plan must:

(a) Be appropriate in relation to the benefits and the pattern of premiums for that plan, and

(b) Be computed by a method which is consistent with the principles of this Standard Valuation Law as determined by regulations promulgated by the commissioner.

(9) **Actuarial opinion of reserves:** — (a) Actuarial opinion prior to the operative date of the valuation manual.

(i) General. Every life insurance company doing business in this state annually shall submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The commissioner by regulation shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(ii) Actuarial analysis of reserves and assets supporting reserves.

(A) Every life insurance company, except as exempted by or in accordance with regulation, shall also annually include in the opinion required by paragraph (a) of this subsection an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(B) The commissioner may provide by regulation for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this subsection.

(iii) Each opinion required by subsection (9)(a)(ii) of this subsection shall be governed by the following provisions:

(A) A memorandum, in form and substance acceptable to the commissioner as specified by regulation, shall be prepared to support each actuarial opinion.

(B) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and

prepare such supporting memorandum as is required by the commissioner.

(iv) Every opinion required by subsection (9)(a) shall be governed by the following provisions:

(A) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994.

(B) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by regulation.

(C) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by regulation prescribe.

(D) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(E) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in such regulations.

(F) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion.

(G) Disciplinary action by the commissioner against the company or the qualified actuary shall be defined in regulations by the commissioner.

(H) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, shall be kept confidential by the commissioner and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by regulations promulgated hereunder; however, the memorandum or other material may otherwise be released by the commissioner with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

(b) Actuarial opinion of reserves after the operative date of the valuation manual.

(i) General. Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this state and subject to regulation by the commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

(ii) Actuarial analysis of reserves and assets supporting reserves. Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this state and subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by subparagraph (i) of this subsection (9)(b), an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(iii) Each opinion required by subsection (9)(b)(ii) shall be governed by the following provisions:

(A) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the commissioner, shall be prepared to support each actuarial opinion.

(B) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(iv) Requirements for all opinions subject to subsection (9)(b):

(A) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner.

(B) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

(C) The opinion shall apply to all policies and contracts subject to subsection (9) (b) (ii), plus other actuarial liabilities as may be specified in the valuation manual.

(D) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual.

(E) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(F) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion.

(G) Disciplinary action by the commissioner against the company or the appointed actuary shall be defined in regulations by the commissioner.

(10) For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (2)(b). For accident and health insurance contracts issued on or after April 14, 1948, and prior to the operative date of the valuation manual, the minimum standard valuation is the standard prescribed by the applicable laws and regulations of this state.

(11) **Valuation manual for policies issued on or after the operative date of the valuation manual:** — (a) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (2)(b), except as provided under paragraph (e) or (g) of this subsection.

(b) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(i) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two (42) members, or three-fourths (¾) of the members voting, whichever is greater.

(ii) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

(iii) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the following fifty-five (55)

jurisdictions: The fifty (50) States of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(c) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(i) At least three-fourths (¾) of the members of the NAIC voting, but not less than a majority of the total membership; and

(ii) Members of the NAIC representing jurisdictions totaling greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subsection (c)(i)(A): life, accident and health annual statements, health annual statements, or fraternal annual statements.

(d) The valuation manual must specify all of the following:

(i) Minimum valuation standards for and definitions of the policies or contracts subject to subsection (2)(b). Such minimum valuation standards shall be:

(A) The commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to subsection (2)(b);

(B) The commissioners annuity reserve valuation method for annuity contracts subject to subsection (2)(b); and

(C) Minimum reserves for all other policies or contracts subject to subsection (2)(b).

(ii) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in subsection (12)(a) and the minimum valuation standards consistent with those requirements;

(iii) For policies and contracts subject to a principle-based valuation under subsection (12):

(A) Requirements for the format of reports to the commissioner under subsection (12)(b)(iii) and which shall include information necessary to determine if the valuation is appropriate and in compliance with this section;

(B) Assumptions shall be prescribed for risks over which the company does not have significant control or influence.

(C) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures.

(iv) For policies not subject to a principle-based valuation under subsection (12) the minimum valuation standard shall either:

(A) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(B) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(v) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

(vi) The data and form of the data required under subsection (13), with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(e) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this section, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by regulation.

(f) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this section. The commissioner may rely upon the opinion, regarding provisions contained within this section, of a qualified actuary engaged by the commissioner of another state, district or territory of the United States. As used in this paragraph, the term "engage" includes employment and contracting.

(g) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this section; and the company shall adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted.

(12) **Requirements of a principle-based valuation:** — (a) A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(i) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For polices or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

(ii) Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk-assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(iii) Incorporate assumptions that are derived in one (1) of the following manners:

(A) The assumption is prescribed in the valuation manual.

(B) For assumptions that are not prescribed, the assumptions shall:

1. Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

2. To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(iv) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(b) A company using a principle-based valuation for one or more policies or contracts subject to this subsection as specified in the valuation manual shall:

(i) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(ii) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(iii) Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(c) A principle-based valuation may include a prescribed formulaic reserve component.

(13) Experience reporting for policies in force on or after the operative date of the valuation manual.

(a) A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(b) Experience reporting required by paragraph (a) of this subsection; actuarial memorandums required by subsection (9)(b); reserve examinations, and materials in support thereof, required by subsection (11)(f); materials supporting certification required by subsection (12)(b)(ii); and principle based reserve reports required by subsection (12)(b)(iii) are memorandum in support of the opinion and other material provided by the company to the commissioner in connection therewith, and are subject to subsection (9)(a)(iii)(H) of this section.

(14) **Sharing of information.** — (a) In order to assist in the performance of the commissioner's duties, the commissioner, at his option, may share information obtained pursuant to this section with other state, federal and international regulatory agencies and with the NAIC and its affiliates and subsidiaries, with the Actuarial Board for Counseling and Discipline or its successor, and with state, federal and international law enforcement officials.

(b) The commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged docu-

ments, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the data, document, material or other information, and such information shall be treated by all courts in this state as privileged and confidential as it would be treated under the laws of the jurisdiction that is the source of such data, document, material or other information.

(c) The commissioner may enter into agreements governing sharing and use of information consistent with this section.

(d) In this subsection (14) "regulatory agency," "law enforcement agency" and the "NAIC" include, but are not limited to, their employees, agents, consultants and contractors.

(15) **Single state exemption.** — (a) The commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in Mississippi from the requirements of subsection (11) provided:

(i) The commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(ii) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the commissioner and promulgated by regulation.

(b) For any company granted an exemption under this subsection, subsections (3), (3-a), (3-b), (4), (4-a), (5), (6), (7), (8), (9) and (10) shall be applicable. With respect to any company applying this exemption, any reference to subsection (11) found in subsections (3), (3-a), (3-b), (4), (4-a), (5), (6), (7), (8), (9) and (10) shall not be applicable.

SOURCES: Codes, 1942, § 5669-02; Laws, 1948, ch. 345, § 2; Laws, 1962, ch. 460, § 1; Laws, 1966, ch. 523, § 1; Laws, 1975, ch. 412, § 1; Laws, 1979, ch. 314, § 1; Laws, 1983, ch. 316, § 1; Laws, 1994, ch. 314, § 1; Laws, 2014, ch. 410, § 1, eff from and after July 1, 2014.

Amendment Notes — The 2014 amendment added (1)(a), (1)(b), (2)(a), (2)(b), (10) through (15), and redesignated the remaining subsections accordingly; in (2)(a)(i), deleted "and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest, and methods (net level premium method or other) used in the calculation of such reserves" at the end of the first sentence, "herein" following "valuation complies with the minimum standard", and substituted "in this section" for "and if the official of such other state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the Mississippi Insurance Commissioner when the certificate of the Mississippi Commissioner states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by law of that other state or jurisdiction," substituted "the commissioner" for "he" in two places,

and inserted "issued on or after ... the valuation manual," in the first sentence; in (3)(a)(iii), (3)(b), (3)(e), (3)(f), substituted "NAIC" for "National Association of Insurance Commissioners" and "which" for "that"; in (3)(b), deleted "all" preceding "industrial life insurance policies" at the beginning; added (3-a)(a) and renumbered former (3-a)(a) through (3-a)(e) as (3-a)(i) through (3-a)(v) and redesignated former undesignated paragraph under former (3-a)(e) as present (3-a)(b); in present (3-a)(ii) and (3-a)(iii), substituted "NAIC, which" for "National Association of Insurance Commissioners that"; and in present (3-a)(v), substituted "NAIC" for "National Association of Insurance Commissioners" and "which" for "that"; in (3-b)(a), deleted the "(i)" designator following "Applicability of this subsection." and redesignated former (3-b)(a)(i)(A) through (3-b)(a)(i)(D) as present (3-b)(a)(i) through (3-b)(a)(iv); in (3-b)(a), added "the following ... in this subsection" to the end and in (3-b)(a)(i), (3-b)(a)(ii), and (3-b)(a)(iii), deleted "All" following each designator, deleted former (3-b)(a)(ii) and (3-b)(e)(ii), which read "[Blank]", deleted the "(i)" designator from (3-b)(e)(i) and substituted "NAIC" for "National Association of Insurance Commissioners"; in the second undesignated paragraph of (4)(b), clause (iv), substituted "subsection" for "section" at the end; in the first undesignated paragraph of (6), substituted "greater" for "higher" and "in the policies or contracts" for "herein", and in the second undesignated paragraph, deleted "such" preceding "company which at any time"; added (9)(a)(i) and redesignated former (9)(b) through (9)(d) as present (9)(a)(ii) through (9)(a)(iv); in present (9)(a)(ii)(B), substituted "subsection" for "section", in present (9)(a)(iii), substituted "subsection (9)(a)(ii)" for "paragraph (b)", added "required by subsection (9)(a)" to (9)(a)(iv), added present (9)(b), and deleted former (9)(e), which read "This subsection shall become operative with the filing of the December 31, 1994, annual statement."

§ 83-7-25. Standard nonforfeiture law.

(1) **Title:** — This section shall be known as the standard nonforfeiture law for life insurance.

(1-a) Definitions: The term "operative date of the valuation manual" means the January 1 of the first calendar year that the valuation manual as defined in Section 83-7-23 is effective.

(2) **Nonforfeiture provisions:** — In the case of policies issued on or after the operative date of this section as defined in subsection (10), no policy of life insurance, except as stated in subsection (9), shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the Commissioner of Insurance are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with subsection (8) of this section:

(a) That, in the event of default in any premium payment, the company will grant, upon proper request not later than sixty (60) days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be hereinafter specified.

In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty (60) days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(b) That, upon surrender of the policy within sixty (60) days after the due date of any premium payment in default after premiums have been paid for at least three (3) full years in the case of ordinary insurance or five (5) full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

(c) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty (60) days after the due date of the premium in default.

(d) That, if the policy shall have become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty (30) days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

(e) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty (20) policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six (6) months after demand therefor with surrender of the policy.

(3) **Computation of cash surrender value:** — Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection (2), shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of (1) the then present value of the adjusted premiums as defined in subsections (5), (5-a), (5-b) and (5-c), corresponding to premiums which would have fallen due on and after such anniversary, and (2) the amount of any indebtedness to the company on the policy.

Provided, however, that for any policy issued on or after the operative date of subsection (5-c) as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

Provided, further, that for any family policy issued on or after the operative date of subsection (5-c) as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age of seventy-one (71) years, the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

Any cash surrender value available within thirty (30) days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by subsection (2), shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by an indebtedness to the company on the policy.

(4) **Computation of paid-up nonforfeiture benefits:** — Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present

value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(5) **Calculation of adjusted premiums:** — This subsection (5) shall not apply to policies issued on or after the operative date of subsection (5-c) as defined therein. Except as provided in the third paragraph of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of (1) the then present value of the future guaranteed benefits provided for by the policy; (2) two percent (2%) of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (3) forty percent (40%) of the adjusted premium for the first policy year; (4) twenty-five percent (25%) of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. Provided, however, that in applying the percentages specified in (3) and (4) above, no adjusted premium shall be deemed to exceed four percent (4%) of the amount of insurance or level amount equivalent thereto. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent level amount thereof for the purpose of this subsection shall be deemed to be the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy.

The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (a) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) being calculated separately and as specified in the first two (2) paragraphs of this subsection except that, for the purposes of (2), (3) and (4) of the first such paragraph, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

Except as otherwise provided in subsections (5-a) and (5-b), all adjusted premiums and present values referred to in this section shall for all policies of

ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three (3) years younger than the actual age of the insured, and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent (3-½%) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred thirty percent (130%) of the rates of mortality according to such applicable table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present value may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(5-a) **Calculation of adjusted premiums-ordinary policies:** — This subsection (5-a) shall not apply to ordinary policies issued on or after the operative date of subsection (5-c) as defined therein. In the case of ordinary policies issued on or after the operative date of this subsection (5-a) as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed three and one-half percent (3-½%) per annum except that a rate of interest not exceeding four percent (4%) per annum may be used for policies issued on or after September 1, 1975, and prior to January 1, 1980, and a rate of interest not exceeding five and one-half percent (5-½%) per annum may be used for policies issued on or after January 1, 1980, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent (6-½%) per annum may be used and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six (6) years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After the effective date of this subsection (5-a), any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1966. After the filing

of such notice, then upon such specified date (which shall be the operative date of this subsection for such company), this subsection shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of this subsection for such company shall be January 1, 1966.

(5-b) **Calculation of adjusted premiums-industrial policies:** — This subsection (5-b) shall not apply to industrial policies issued on or after the operative date of subsection (5-c) as defined therein. In the case of industrial policies issued on or after the operative date of this subsection (5-b) as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that such rate of interest shall not exceed three and one-half percent (3-½%) per annum, except that a rate of interest not exceeding four percent (4%) per annum may be used for policies issued on or after September 1, 1975, and prior to January 1, 1980, and a rate of interest not exceeding five and one-half percent (5-½%) per annum may be used for policies issued on or after January 1, 1980, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent (6-½%) per annum may be used. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After the effective date of this subsection (5-b), any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date (which shall be the operative date of this subsection for such company), this subsection shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this subsection for such company shall be January 1, 1968.

(5-c) **Calculation of adjusted premiums by the nonforfeiture net level premium method:** — (a) This subsection shall apply to all policies issued on or after the operative date of this subsection (5-c) as defined herein. Except as provided in paragraph (g) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that

the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) one percent (1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and (iii) one hundred twenty-five percent (125%) of the nonforfeiture net level premium as hereinafter defined. Provided, however, that in applying the percentage specified in (iii) above no nonforfeiture net level premium shall be deemed to exceed four percent (4%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(b) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one (1) per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(c) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(d) Except as otherwise provided in paragraph (g) of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (A) the sum of (i) the then present value of the then future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(e) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (i) one percent (1%) of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten (10) policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of

the first ten (10) policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (ii) one hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.

(f) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where:

(A) Equals the sum of

(i) The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and

(ii) The present value of the increase in future guaranteed benefits provided for by the policy, and

(B) Equals the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(g) Notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(h) All adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of (i) the Commissioners 1980 Standard Ordinary Mortality Table or (ii) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with ten-year select mortality factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection for policies issued in that calendar year. Provided, however, that:

(i) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.

(ii) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (2), shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(iii) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the

basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(iv) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

(v) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

(vi) For policies issued prior to the operative date of the valuation manual, any commissioner's standard ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without ten-year select mortality factors or for the Commissioners 1980 Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the standard ordinary mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the commissioner approves by regulation any commissioner's standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(vii) For policies issued prior to the operative date of the valuation manual, any commissioner's standard industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioner's Standard Mortality Table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the commissioner approves by regulation any commissioner's standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual then

that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(i) The nonforfeiture interest rate is defined below:

(i) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent (125%) of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law (Section 83-7-23), rounded to the nearer one-quarter of one percent (¼ of 1%); provided, however, that the nonforfeiture interest rate shall not be less than four percent (4%).

(ii) For policies issued on and after the operative date of the valuation manual the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(j) Notwithstanding any other provision in this section to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(k) After the effective date of this subsection (5-c), any company may file with the commissioner a written notice of its election to comply with the provision s of this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for such company. If a company makes no such election, the operative date of this subsection for such company shall be January 1, 1989.

(6) **Nonforfeiture benefits for indeterminate premium plans:** — In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in subsection (2), (3), (4), (5), (5-a), (5-b) or (5-c) herein, then:

(a) The commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insured as the minimum benefits otherwise required by subsection (2), (3), (4), (5), (5-a), (5-b) or (5-c) herein;

(b) The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(c) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for life insurance, as determined by regulations promulgated by the commissioner.

(7) **Proration of values; net value of paid-up additions:** — Any cash surrender value and any paid-up nonforfeiture benefits, available under the

policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subsections (3), (4), (5), (5-a), (5-b) and (5-c) may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of subsection (3), additional benefits payable (i) in the event of death or dismemberment by accident or accidental means, (ii) in the event of total and permanent disability, (iii) as reversionary annuity or deferred reversionary annuity benefits, (iv) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, (v) as term insurance on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six (26) years, is uniform in amount after the child's age is one (1) year, and has not become paid up by reason of the death of a parent of the child, and (vi) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(8) **Consistency of progression of cash surrender values with increasing policy duration:** — This subsection (8), in addition to all other applicable subsections of this section, shall apply to all policies issued on or after January 1, 1987. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one percent (2/10 of 1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years, from the sum of (a) the greater of zero and the basic cash value hereinafter specified, and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (3), shall be the same as are the effects specified in subsection (3), on the cash surrender values defined in that subsection.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (5-c). Except as is required by the next succeeding sentence of this paragraph, such percentage:

(a) Must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent (2/10 of 1%) in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

(b) Must be such that no percentage after the later of the two (2) policy anniversaries specified in the preceding paragraph (a) may apply to fewer than five (5) consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (5-c), were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (2), (3), (4), (5-c) and (7). The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (i) through (vi) in subsection (7) shall conform with the principles of this subsection (8).

(9) **Exceptions:** — This section shall not apply to any of the following:

(a) Reinsurance,

(b) Group insurance,

(c) Pure endowment,

(d) Annuity or reversionary annuity contract,

(e) Term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy,

(f) Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (5), (5-a), (5-b) and (5-c), is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy,

(g) Policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (3), (4), (5), (5-a), (5-b) and (5-c), exceeds two and one-half percent (2-½%) of the amount of insurance at the beginning of the same policy year, nor

(h) Policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy.

For purposes of determining the applicability of this section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

(10) **Effective date:** — After the effective date of this section, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before April 1, 1948. After the filing of such notice, then upon such specified date (which shall be the operative date for such company) this section shall become operative with respect to the policies thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be April 1, 1948.

SOURCES: Codes, 1942, § 5669-03; Laws, 1948, ch. 345, § 3; Laws, 1962, ch. 460, § 2; Laws, 1966, ch. 523, § 2; Laws, 1975, ch. 412, § 2; Laws, 1979, ch. 314, § 2; Laws, 1983, ch. 316, § 2; Laws, 2014, ch. 410, § 2, eff from and after July 1, 2014.

Amendment Notes — The 2014 amendment added (1-a), (5-c)(i)(i), and (5-c)(i)(ii); in (5), last undesignated paragraph, deleted "and" following "may be not more than one hundred"; in (5-c)(j), substituted "section" for "code"; in (6), substituted "subsection" for "subsections"; in (8), substituted "section" for "law" in two places, "a" for "an", and "paragraph" for "item", inserted "sub" preceding "section" in two places and additional language throughout; in (9) and (10), substituted "section" for "chapter" throughout and "April" for "January" twice in (10).

UNCLAIMED LIFE INSURANCE BENEFITS ACT

SEC.

83-7-301. Short title [Effective July 1, 2015].
83-7-303. Purpose [Effective July 1, 2015].
83-7-305. Definitions [Effective July 1, 2015].
83-7-307. Insurer conduct [Effective July 1, 2015].
83-7-309. Insurer unclaimed property reporting [Effective July 1, 2015].
83-7-311. Limitation on promulgation of rules or regulations that impose additional duties on insurers beyond those set out in Sections 83-7-301 through 83-7-313 [Effective July 1, 2015].
83-7-313. Effect of certain agreements between insurers and Commissioner of Insurance or State Treasurer [Effective July 1, 2015].

§ 83-7-301. Short title [Effective July 1, 2015].

Sections 83-7-301 through 83-7-313 shall be known as the "Unclaimed Life Insurance Benefits Act."

SOURCES: Laws, 2014, ch. 431, § 1, eff from and after July 1, 2015.

§ 83-7-303. Purpose [Effective July 1, 2015].

Sections 83-7-301 through 83-7-313 confirm the applicability of the escheat and unclaimed property statutes of Mississippi to any method of payment for life insurance death benefits regulated by the Mississippi Department of Insurance, and establish the sole standards by which such escheat and unclaimed property statutes are applicable to such payments.

SOURCES: Laws, 2014, ch. 431, § 2, eff from and after July 1, 2015.

§ 83-7-305. Definitions [Effective July 1, 2015].

As used in Sections 83-7-301 through 83-7-313:

(a) "Account owner" means the owner of a retained asset account who is a resident of this state.

(b) "Annuity" means an annuity contract issued in this state. The term "annuity" shall not include any annuity contract used to fund an employment-based retirement plan or program where the insurer takes direction from the plan sponsor and plan administrator.

(c) "Death master file" means the United States Social Security Administration's Death Master File or any other database or service that is at least as comprehensive as the United States Social Security Administration's Death Master File for determining that a person has reportedly died.

(d) "Death master file match" means a search of the death master file that results in a match of a person's name and social security number, or the name and date of birth.

(e) "Insurer" means a life insurance company as defined in Section 83-7-1.

(f) "Knowledge of death" shall, for purposes of Sections 83-7-301 through 83-7-313, for purposes of Section 83-7-6, and for purposes of establishing the presumption of abandonment of funds held or owing by a life insurance corporation under Section 89-12-7 mean (i) receipt of an original or valid copy of a certified death certificate, or (ii) a death master file match validated by a secondary source by the insurer.

(g) "Person" means the policy owner, insured, annuity owner, annuitant or account owner, as applicable under the policy, annuity, or retained asset account subject to Sections 83-7-301 through 83-7-313.

(h) "Policy" means any policy or certificate of life insurance issued in this state; except the term "policy" shall not include (i) any policy or certificate of life insurance that provides a death benefit under an employee benefit plan subject to The Employee Retirement Income Security Act of 1974 [29 USC 1002], as periodically amended, or under any federal employee benefit program, (ii) any policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement, (iii) any policy or certificate of credit life or accidental death insurance, (iv) any policy or

certificate of industrial life insurance, or (v) any policy issued to a group master policyholder for which the insurer does not provide record keeping services.

(i) "Record keeping services" means those circumstances under which the insurer has agreed with a group policyholder to be responsible for obtaining, maintaining and administering in its own systems information about each individual insured under an insured's group insurance contract (or a line of coverage thereunder), at least the following information: (i) social security number or name and date of birth, (ii) beneficiary designation information, (iii) coverage eligibility, (iv) benefit amount, and (v) premium payment status.

SOURCES: Laws, 2014, ch. 431, § 3, eff from and after July 1, 2015.

§ 83-7-307. Insurer conduct [Effective July 1, 2015].

(1) An insurer shall perform a comparison of its in-force policies, annuities and retained asset accounts issued in this state against a death master file, on at least a semiannual basis, to identify potential death master file matches.

(a) An insurer may comply with the requirements of this section by using the full death master file once annually and using the death master file update files for the remaining comparisons in that year.

(b) Nothing in this section shall limit the insurer from requesting a valid death certificate as part of any claims validation process.

(2) If an insurer obtains knowledge of the death of a person, then the insurer shall within ninety (90) days:

(a) Complete a good-faith effort, which shall be documented by the insurer, to confirm the death of the person against other available records and information;

(b) Review its records to determine whether the deceased person had purchased any other products with the insurer;

(c) Determine whether benefits may be due in accordance with any applicable policy, annuity or retained asset account issued or assumed by the insurer; and

(d) If the beneficiary or other authorized representative has not communicated with the insurer within the ninety-day period, take reasonable steps, which shall be documented by the insurer, to locate and contact the beneficiary or beneficiaries or other authorized representative on any such policy, annuity or retained asset account, including, but not limited to, sending the beneficiary information regarding the insurer's claims process, including the need to provide an official death certificate if applicable under the policy, annuity or retained asset account.

(e) In the event the insurer is unable to confirm the death of a person following a death master file match, an insurer may consider such policy, annuity or retained asset account to be in force in accordance with its terms.

(3) An insurer shall not be required to do the comparison under this section or take the steps described in this section with respect to policies, annuities or retained asset accounts issued and delivered prior to July 1, 2015.

(4) To the extent permitted by law, an insurer may disclose minimum necessary personal information about a person or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer in locating the beneficiary or a person otherwise entitled to payment of the policy, annuity or retained asset account proceeds.

(5) An insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

(6) The benefits from a policy, annuity or retained asset account, plus any applicable accrued contractual interest shall first be payable to the designated beneficiaries or owners and in the event said beneficiaries or owners cannot be found, shall escheat to the state as unclaimed property pursuant to Section 89-12-7. Interest payable under Section 83-7-6 shall not be payable as unclaimed property under Section 89-12-7(1) or (3).

(7) The Commissioner of Insurance shall have exclusive authority and jurisdiction on behalf of the State Treasurer to examine the records of insurers to determine if they have complied with the Mississippi escheat and unclaimed property laws, and may adopt such rules and regulations as may be reasonably necessary to implement the provisions of Sections 83-7-301 through 83-7-313.

(8) The Commissioner of Insurance may, in his or her reasonable discretion, make an order:

(a) Limiting an insurer's death master file comparisons required under subsection (1) to the insurer's electronic searchable files or approving a plan and timeline for conversion of the insurer's files to electronic searchable files;

(b) Exempting an insurer from the death master file comparisons required under subsection (1) or permitting an insurer to perform such comparisons less frequently than semiannually upon a demonstration of financial hardship by the insurer; or

(c) Phasing-in compliance with this section according to a plan and timeline approved by the Commissioner of Insurance.

(9) A violation of Sections 83-7-301 through 83-7-313 shall be subject to the penalty provisions set forth in Section 83-5-17, as well as other penalty provisions under applicable law. Nothing herein shall be construed to create or imply a private cause of action for a violation of Sections 83-7-301 through 83-7-313.

SOURCES: Laws, 2014, ch. 431, § 4, eff from and after July 1, 2015.

§ 83-7-309. Insurer unclaimed property reporting [Effective July 1, 2015].

In the event that an insurer: (a) has identified a person as deceased through a death master file match through a search described in Section

83-7-307(1) or other information source, (b) has validated such information through a secondary information source, and (c) is unable to locate a beneficiary under the policy, annuity or retained asset account after conducting reasonable search efforts during the period of up to one (1) year after the insurer's validation of the death master file match, or if no beneficiary, if the person, as applicable for unclaimed reporting purposes, has a last-known address in this state, then the insurer is authorized to report and remit the proceeds of such policy, annuity or retained asset account due to the state on an early reporting basis, without further notice or consent by the state, after attempting to contact such beneficiary pursuant to Section 89-12-7. Once reported and proceeds are remitted, the insurer shall be relieved and indemnified from any and all additional liability to any person relating to the proceeds reported and remitted, including, but not limited to, any liability under for all proceeds reported and remitted to the state pursuant to Sections 83-7-301 through 83-7-313. This indemnification from liability shall be in addition to any other protections provided by law. Any proceeds remitted to the state pursuant to Sections 83-7-301 through 83-7-313 shall be deposited in the Abandoned Property Fund maintained by the State Treasurer.

SOURCES: Laws, 2014, ch. 431, § 5, eff from and after July 1, 2015.

§ 83-7-311. Limitation on promulgation of rules or regulations that impose additional duties on insurers beyond those set out in Sections 83-7-301 through 83-7-313 [Effective July 1, 2015].

Neither the Commissioner of Insurance nor the State Treasurer shall promulgate rules, regulations or issue bulletins that impose, or interpret Sections 83-7-301 through 83-7-313 to impose, additional duties and obligations on insurers beyond those set forth in Sections 83-7-301 through 83-7-313, or otherwise attempt to expand the requirements of Sections 83-7-301 through 83-7-313.

SOURCES: Laws, 2014, ch. 431, § 6, eff from and after July 1, 2015.

§ 83-7-313. Effect of certain agreements between insurers and Commissioner of Insurance or State Treasurer [Effective July 1, 2015].

In the event that any resolution agreement, regulatory settlement agreement, or a voluntary disclosure agreement between an insurer who has used the death master file to terminate annuity payments but not to locate life beneficiaries and the Commissioner of Insurance or the State Treasurer conflicts with Sections 83-7-301 through 83-7-313, the terms of the agreement shall supersede Sections 83-7-301 through 83-7-313.

SOURCES: Laws, 2014, ch. 431, § 7, eff from and after July 1, 2015.

CHAPTER 9

Accident, Health and Medicare Supplement Insurance

Accident and Health Insurance 83-9-1
Coverage for Treatment of Mental Illness, Temporomandibular Joint Disorder and Craniomandibular Disorder 83-9-37
Comprehensive Health Insurance Risk Pool Association 83-9-201
Coverage for Telemedicine Services 83-9-351

ACCIDENT AND HEALTH INSURANCE

SEC.
83-9-3. Form of policy; commissioner's fees; expedited form and rate review procedure.
83-9-4. Commissioner may disapprove policy form, amendatory rider or endorsement currently in effect under certain circumstances; procedure; applicability.
83-9-5. Policy provisions.
83-9-6.3. Standardized prior authorization form for obtaining prior authorization for prescription drug benefits.
83-9-22. Health coverage plans prohibited from restricting coverage for medically appropriate treatment prescribed by physician based on insured's diagnosis with terminal condition.

§ 83-9-3. Form of policy; commissioner's fees; expedited form and rate review procedure.

(1) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

(a) The entire money and other considerations therefor are expressed therein; and

(b) The time at which the insurance takes effect and terminates is expressed therein; and

(c) It purports to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed nineteen (19) years, and any other person dependent upon the policyholder; and

(d) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lowercase unspaced alphabet length not less than one-hundred-twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions); and

(e) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Section 83-9-5, are printed, at the insurer's option, either with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions," provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(f) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(g) It contains no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(2) No individual or group policy covering health and accident insurance (including experience-rated insurance contracts, indemnity contracts, self-insured plans and self-funded plans), or any group combinations of these coverages, shall be issued by any commercial insurer doing business in this state which, by the terms of such policy, limits or excludes payment because the individual or group insured is eligible for or is being provided medical assistance under the Mississippi Medicaid Law. Any such policy provision in violation of this section shall be invalid.

(3) No individual or group policy covering health and accident insurance (including experience-rated insurance contracts, indemnity contracts, self-insured plans and self-funded plans) or any group combinations of these coverages, shall be issued by any commercial insurer doing business in this state, which, by the terms of such policy, limits or restricts the insured's ability to assign the insured's benefits under the policy to a licensed health care provider that provides health care services to the insured. Commercial insurers doing business in this state shall honor an assignment for a period of one (1) year starting from the initial date of an assignment or until the insured revokes the assignment, whichever occurs first. Any such policy provision in violation of this subsection shall be invalid.

(4) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may, by ruling, require that such policy meet the standards set forth in subsection (1) of this section and in Section 83-9-5.

(5) The commissioner shall collect and pay into the special fund in the State Treasury designated as the "Insurance Department Fund" the following fees for services provided under this section:

FORM	FEE
Each individual policy contract, including revisions	$15.00
Each group master policy or contract, including revisions	15.00

Each rider, endorsement or amendment, etc 10.00
Each insurance application where written application
is required and is to be made a part of the policy or contract 10.00
Each questionnaire 7.00
Charge for resubmission where payment is not included
with original submission 5.00
Additional charge for tentative approval same as above.

(6) In order to expedite and become more efficient in reviewing and approving accident and health form and rate filings, the commissioner may establish an expedited form and rate review procedure whereby insurers may elect to pay reasonable actuarial fees directly to a department-approved actuarial service in exchange for an expedited review of form and rate filings by the actuarial service. The commissioner may make such reasonable rules and regulations concerning the expedited procedure, and may set reasonable fees for the actuarial services provided. This provision shall not abridge any other authority granted to the commissioner by law, including the authority to collect the filing fees prescribed by this section.

SOURCES: Codes, 1942, § 5687-02; Laws, 1956, ch. 330, § 2; Laws, 1988, ch. 526, § 4; Laws, 1989, ch. 408, § 1; Laws, 1991, ch. 354 § 1; Laws, 1997, ch. 324, § 3; Laws, 2008, ch. 432, § 2; Laws, 2013, ch. 302, § 1; Laws, 2014, ch. 404, § 1, eff from and after July 1, 2014.

Amendment Notes — The 2013 amendment, added (3), redesignated former (3) through (5), as present (4) through (6).

The 2014 amendment inserted the second to last sentence in (3).

§ 83-9-4. Commissioner may disapprove policy form, amendatory rider or endorsement currently in effect under certain circumstances; procedure; applicability.

(1) The Commissioner of Insurance may disapprove a policy form, amendatory rider or endorsement currently in effect if the commissioner finds that a portion or all of the policy form, amendatory rider or endorsement:

(a) Is in any respect in violation of any state or federal laws; or

(b) Contains or incorporates by reference any inconsistent, ambiguous or misleading clauses or exceptions and conditions.

(2) If the commissioner disapproves a policy form, amendatory rider or endorsement currently in effect, the commissioner shall issue an order only after a hearing held on not less than thirty (30) days written notice to the filing insurer. The insurer may waive the hearing. The commissioner shall issue an order within thirty (30) days after the close of the hearing or within thirty (30) days after the filing of a waiver of hearing and shall specify in what respects the policy form, amendatory rider or endorsement fails to meet the requirements of this section. The commissioner may extend the thirty-day period for issuance of an order for an additional thirty (30) days.

(3) This section may apply to any health insurance policy or employee health benefit plan which is delivered, renewed, issued for delivery, or

otherwise contracted for in this state, but shall not apply to any policy of disability income insurance or long-term care insurance.

(4) The commissioner may promulgate rules and regulations necessary to carry out the provisions of this section.

SOURCES: Laws, 2014, ch. 405, § 1, eff from and after passage (approved Mar. 19, 2014.)

§ 83-9-5. Policy provisions.

(1) **Required provisions.** — Except as provided in subsection (3) of this section, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section. However, the insurer may, at its option, substitute for one or more of such provisions, corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

As used in this section, the term "insurer" means a health maintenance organization, an insurance company or any other entity responsible for the payment of benefits under a policy or contract of accident and sickness insurance; however, the term "insurer" shall not mean a liquidator, rehabilitator, conservator or receiver or third-party administrator of any health maintenance organization, insurance company or other entity responsible for the payment of benefits which is in liquidation, rehabilitation or conservation proceedings, nor shall it mean any responsible guaranty association. Further, no cause of action shall accrue against a liquidator, rehabilitator, conservator or receiver or third-party administrator of any health maintenance organization, insurance company or other entity responsible for the payment of benefits which is in liquidation, rehabilitation or conservation proceedings or any responsible guaranty association under paragraph (h)3 of this subsection or any policy provision in accordance therewith.

(a) A provision as follows:

Entire contract; changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(b) A provision as follows:

Time limit on certain defenses:

1. After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

(The foregoing policy provision shall not be so construed as to effect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subsection (2) (a) and (2) (b) of this section in the event of misstatement with respect to age or occupation.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty (50) or, (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements in the application.)

2. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(c) A provision as follows:

Grace period:

A grace period of seven (7) days for weekly premium policies, ten (10) days for monthly premium policies and thirty-one (31) days for all other policies will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "unless not less than five (5) days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.")

(d) A provision as follows:

Reinstatement:

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. However, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured

in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement. (The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty (50) or, (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue.)

(e) A provision as follows:

Notice of claim:

Written notice of claim must be given to the insurer within thirty (30) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss of time benefit which may be payable for at least two (2) years, an insurer may, at its option, insert the following between the first and second sentences of the above provision: "Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, he shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability, in whole or in part, by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.")

(f) A provision as follows:

Claim forms:

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(g) A provision as follows:

Proofs of loss:

Written proof of loss must be furnished to the insurer at its said office, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within ninety (90) days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

(h) A provision as follows:

Time of payment of claims:

1. All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A "clean claim" means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

A clean claim does not include any of the following:

a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;

b. Claims which are submitted fraudulently or that are based upon material misrepresentations;

c. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or

d. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

Not later than twenty-five (25) days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the insurer actually receives a paper claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be paid within twenty (20) days after receipt.

For purposes of this provision, the term "pay" means that the insurer shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or insured.

2. Subject to due written proof of loss, all accrued benefits for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly), and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.

3. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of one and one-half percent (1-½%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

4. In the event the insurer fails to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any

interest which may accrue as provided in paragraph (h)3 of this subsection and any other damages as may be allowable by law.

(i) A provision as follows:

Payment of claims:

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. The notification requirement shall not apply to a fixed-indemnity policy, a limited benefit health insurance policy, medical payment coverage or personal injury protection coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance or workers' compensation. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are noncovered benefits.

(The following provision may be included with the foregoing provision at the option of the insurer: "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $_____ (insert an amount which must not exceed One Thousand Dollars ($1,000.00)), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."

(j) A provision as follows:

Physical examinations:

The insurer at his own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

(k) A provision as follows:

Legal actions:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

(*l*) A provision as follows:

Change of beneficiary:

Unless the insured makes an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the insured, and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy, or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

(2) **Other provisions.** — Except as provided in subsection (3) of this section, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section. However, the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(a) A provision as follows:

Change of occupation:

If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the most recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable, or prior to date of proof of change in occupation, with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(b) A provision as follows:

Misstatement of age:

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(c) A provision as follows:

Relation of earnings to issuance:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of Two Hundred Dollars ($200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty (50) or, (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulations by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner, or any combination of such coverages. In the absence of such definition, such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

(d) A provision as follows:

Unpaid premium:

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(e) A provision as follows:

Cancellation:

The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five (5) days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be

specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(f) A provision as follows:

Conformity with state statutes:

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(g) A provision as follows:

Illegal occupation:

The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(h) A provision as follows:

Intoxicants and narcotics:

The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(3) **Inapplicable or inconsistent provisions.** — If any provision of this section is, in whole or in part, inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(4) **Order of certain policy provisions.** — The provisions which are the subject of subsections (1) and (2) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be, in whole or in part, unintelligible, uncertain, ambiguous, abstruse or likely to mislead a person to whom the policy is offered, delivered or issued.

(5) **Third-party ownership.** — The word "insured," as used in Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured, or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

(6) **Requirements of other jurisdictions.** —

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not

less favorable to the insured or the beneficiary than the provisions of Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, and which is prescribed or required by the law of the state under which the insurer is organized.

(b) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(7) **Filing procedure.** — The commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to the cited sections as are necessary, proper or advisable to the administration of said sections. This provision shall not abridge any other authority granted the commissioner by law.

(8) **Administrative penalties.** —

(a) If the commissioner finds that an insurer, during any calendar year, has paid at least eighty-five percent (85%), but less than ninety-five percent (95%), of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount not to exceed Ten Thousand Dollars ($10,000.00). If the commissioner finds that an insurer, during any calendar year, has paid at least fifty percent (50%), but less than eighty-five percent (85%), of all clean claims received from all providers during that year in accordance with the provisions of subsection (1) (h) of this section, the commissioner may levy an aggregate penalty in an amount of not less than Ten Thousand Dollars ($10,000.00) nor more than One Hundred Thousand Dollars ($100,000.00). If the commissioner finds that an insurer, during any calendar year, has paid less than fifty percent (50%) of all clean claims received from all providers during that year in accordance with the provisions of subsection (1) (h) of this section, the commissioner may levy an aggregate penalty in an amount not less than One Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred Thousand Dollars ($200,000.00). In determining the amount of any fine, the commissioner shall take into account whether the failure to achieve the standards in subsection (1)(h) of this section were due to circumstances beyond the control of the insurer. The insurer may request an administrative hearing to contest the assessment of any administrative penalty imposed by the commissioner pursuant to this subsection within thirty (30) days after receipt of the notice of assessment.

(b) Examinations to determine compliance with subsection (1)(h) of this section may be conducted by the commissioner or any of his examiners. The commissioner may contract with qualified impartial outside sources to assist in examinations to determine compliance. The expenses of any such examinations shall be paid by the insurer examined.

(c) Nothing in the provisions of subsection (1)(h) of this section shall require an insurer to pay claims that are not covered under the terms of a contract or policy of accident and sickness insurance.

(d) An insurer and a provider may enter into an express written agreement containing timely claim payment provisions which differ from,

but are at least as stringent as, the provisions set forth under subsection (1) (h) of this section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the insurer to the provider. If the express written agreement is silent as to any interest penalty where claims are not paid in accordance with the agreement, the interest penalty provision of subsection (1) (h)3 of this section shall apply.

(e) The commissioner may adopt rules and regulations necessary to ensure compliance with this subsection.

SOURCES: Codes, 1942, § 5687-03; Laws, 1956, ch. 330, § 3; Laws, 1989, ch. 466, § 1; Laws, 1991, ch. 474, § 2; Laws, 2002, ch. 575, § 1; Laws, 2013, ch. 302, § 2; brought forward without change, Laws, 2014, ch. 404, § 2, eff from and after July 1, 2014.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected errors in this section. Corrected reference terminology in (1), (1)(b)1 and (1)(h) 4. The Joint Committee ratified the corrections at its August 16, 2012, meeting.

Amendment Notes — The 2013 amendment, substituted "paragraph (h)3 of this subsection" for "subsection (1)(h)3 of this section" in the last sentence of the last paragraph in (1), and in (1)(h)4; substituted "subsection" for "subparagraph" in the second paragraph of (1)(b)1.; added the last two sentences in the second paragraph of (1)(i) and deleted "s, or either of them" from the beginning of the third paragraph and first sentence of (1)(b)(i); and deleted the former last sentence which read: "Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person").

The 2014 amendment brought forward the section without change.

§ 83-9-6. Freedom of consumer choice for pharmacy under certain health insurance.

JUDICIAL DECISIONS

2. Applicablity.

Miss. Code Ann. § 83-9-6 applies to the Mississippi State and School Employees' Life and Health Plan because it applies to "all health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of Mississippi" and is not ambiguous. Miss. State & Sch. Emples. Life & Health Plan v. KCC, Inc., 108 So. 3d 932 (Miss. 2013).

§ 83-9-6.3. Standardized prior authorization form for obtaining prior authorization for prescription drug benefits.

(1) As used in this section:

(a) "Health benefit plan" means services consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan con-

tract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer. The term "health benefit plan" includes the Medicaid fee-for-service program and any managed care program, coordinated care program, coordinated care organization program or health maintenance organization program implemented by the Division of Medicaid.

(b) "Health insurance issuer" means any entity that offers health insurance coverage through a health benefit plan, policy, or certificate of insurance subject to state law that regulates the business of insurance. "Health insurance issuer" also includes a health maintenance organization, as defined and regulated under Section 83-41-301 et seq., and includes the Division of Medicaid for the services provided by fee-for-service and through any managed care program, coordinated care program, coordinated care organization program or health maintenance organization program implemented by the division.

(c) "Prior authorization" means a utilization management criterion used to seek permission or waiver of a drug to be covered under a health benefit plan that provides prescription drug benefits.

(d) "Prior authorization form" means a standardized, uniform application developed by a health insurance issuer for the purpose of obtaining prior authorization.

(2) Notwithstanding any other provision of law to the contrary, in order to establish uniformity in the submission of prior authorization forms, on or after January 1, 2014, a health insurance issuer shall use only a single, standardized prior authorization form for obtaining any prior authorization for prescription drug benefits. The form shall not exceed two (2) pages in length, excluding any instructions or guiding documentation. The form shall also be made available electronically, and the prescribing provider may submit the completed form electronically to the health benefit plan. Additionally, the health insurance issuer shall submit its prior authorization forms to the Mississippi Department of Insurance to be kept on file on or after January 1, 2014. A copy of any subsequent replacements or modifications of a health insurance issuer's prior authorization form shall be filed with the Mississippi Department of Insurance within fifteen (15) days prior to use or implementation of such replacements or modifications.

(3) A health insurance issuer shall respond within two (2) business days upon receipt of a completed prior authorization request from a prescribing provider that was submitted using the standardized prior authorization form required by subsection (2) of this section.

SOURCES: Laws, 2013, ch. 508, § 1, eff from and after July 1, 2013.

§ 83-9-22. Health coverage plans prohibited from restricting coverage for medically appropriate treatment prescribed by physician based on insured's diagnosis with terminal condition.

(1)(a) Notwithstanding any other provision of the law to the contrary, no health coverage plan shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed insured, or if the insured lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an insured's diagnosis with a terminal condition. Refusing to pay for treatment rendered to an insured near the end of life that is consistent with best practices for treatment of a disease or condition, approved uses of a drug or device, or uses supported by peer reviewed medical literature, is a per se violation of this section.

(b) Violations of this section shall constitute an unfair trade practice and subject the violator to the penalties provided by law.

(c) As used in this section "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

(d) As used in this section, a "health coverage plan" shall mean any hospital, health or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and the State Health and Life Insurance Plan.

(2)(a) Notwithstanding any other provision of the law to the contrary, no health benefit paid directly or indirectly with state funds, specifically Medicaid, shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed individual, or if the individual lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an individual's diagnosis with a terminal condition.

(b) Refusing to pay for treatment rendered to an individual near the end of life that is consistent with best practices for treatment of a disease or condition, approved uses of a drug or device, or uses supported by peer reviewed medical literature, is a per se violation of this section.

(c) As used in this section "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

SOURCES: Laws, 2014, ch. 439, § 1, eff from and after July 1, 2014.

COVERAGE FOR TREATMENT OF MENTAL ILLNESS, TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR DISORDER

SEC.

83-9-39. Coverage.
83-9-40. Repealed.
83-9-41. Mental illness benefits.

§ 83-9-39. Coverage.

(1)(a) Except as otherwise provided herein, all alternative delivery systems and all group health insurance policies, plans or programs regulated by the State of Mississippi shall provide covered benefits for the treatment of mental illness, except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies and negotiated labor contracts.

(b) Health insurance policies, plans or programs of any employer of one hundred (100) or fewer eligible employees and all individual health insurance policies which are regulated by the State of Mississippi which do not currently offer benefits for treatment of mental illness shall offer covered benefits for the treatment of mental illness, except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies and negotiated labor contracts.

(2) Covered benefits for inpatient treatment of mental illness in insurance policies and other contracts subject to Sections 83-9-37 through 83-9-43 shall be limited to inpatient services certified as necessary by a health service provider.

(3) Covered benefits for outpatient treatment of mental illness in insurance policies and other contracts subject to Sections 83-9-37 through 83-9-43 shall be limited to outpatient services certified as necessary by a health service provider.

(4) Before an insured party may qualify to receive benefits under Sections 83-9-37 through 83-9-43, a health service provider shall certify that the individual is suffering from mental illness and refer the individual for the appropriate treatment.

(5) All mental illness, treatment or services with respect to such treatment eligible for health insurance coverage shall be subject to professional utilization and peer review procedures.

(6) The provisions of this section shall apply only to alternative delivery systems and individual and group health insurance policies, plans or programs issued or renewed after July 1, 1991.

(7) The exclusion period for coverage of a preexisting mental condition shall be the same period of time as that for other medical illnesses covered under the same plan, program or contract.

SOURCES: Laws, 1991, ch. 570, § 2; reenacted without change by Laws, 1994, ch. 354, § 2; Laws, 2001, ch. 533, § 1; Laws, 2014, ch. 308, § 1, eff from and after July 1, 2014.

Editor's Note — Section 83-9-40 referred to in (1)(a), was repealed by Laws, 2014, ch. 308, § 3 repealed effective July 1, 2014.

Laws of 2014, ch. 308, § 4, provides:

"SECTION 4. This act shall take effect and be in force from and after July 1, 2014, and shall apply only to alternative delivery systems and individual and group health insurance policies, plans or programs issued or renewed on or after July 1, 2014."

Amendment Notes — The 2014 amendment deleted the former last sentence in (1)(a), which read: "This coverage for treatment of mental illness shall not be required if the application of this provision results in an increase in the cost under the plan or coverage of one percent (1%) or more as determined in Section 83-9-40"; and deleted the former last sentence of (1)(b), which read: "This coverage shall be offered on an optional basis, but the owner of the policy, plan or program must reject such coverage in writing."

§ 83-9-40. Repealed.

Repealed by Laws of 2014, ch. 308, § 3, effective from and July 1, 2014.

§ 83-9-40. [Laws, 2001, ch. 533, § 3, eff from and after Jan. 1, 2002.]

Editor's Note — Former § 83-9-40 provided the formula for determining which health insurance policies were required to provide covered benefits for the treatment of mental illness.

§ 83-9-41. Mental illness benefits.

(1) Covered benefits for services in this section shall be limited to coverage of treatment of clinically significant mental illness.

(2) Treatment under this section shall be covered for a minimum of thirty (30) days per year for inpatient services, a minimum of sixty (60) days per year for partial hospitalization, and a minimum of fifty-two (52) outpatient visits per year.

(3) The rate of payment for inpatient services, outpatient services, and partial hospitalization shall be the same as provided for any other condition.

SOURCES: Laws, 1991, ch. 570, § 3; reenacted without change by Laws, 1994, ch. 354, § 3; Laws, 2001, ch. 533, § 2; Laws, 2014, ch. 308, § 2, eff from and after July 1, 2014.

Editor's Note — Laws of 2014, ch. 308, § 4, provides:

"SECTION 4. This act shall take effect and be in force from and after July 1, 2014, and shall apply only to alternative delivery systems and individual and group health insurance policies, plans or programs issued or renewed on or after July 1, 2014."

Amendment Notes — The 2014 amendment in (3), inserted "outpatient services" preceding "and partial hospitalization shall be the same as provided for any other condition" in the first sentence and deleted the former last sentence which read: "The rate of payment for outpatient visits shall be a minimum of fifty percent (50%) of covered expenses which may be limited to a maximum payment of Fifty Dollars ($50.00) per visit."

COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

SEC.
83-9-211. Creation of association; membership; board of directors; adoption of plan, articles, bylaws and operating rules.

§ 83-9-211. Creation of association; membership; board of directors; adoption of plan, articles, bylaws and operating rules.

(1) There is created a nonprofit legal entity to be known as the "Comprehensive Health Insurance Risk Pool Association." All insurers, as a condition of doing business, shall be members of the association.

(2)(a) The association shall operate subject to the supervision and approval of an eleven-member board of directors consisting of:

(i) Six (6) members appointed by the Insurance Commissioner. Two (2) of the commissioner's appointees shall be chosen from the general public and shall not be associated with the medical profession, a hospital or an insurer. Two (2) appointees shall be representatives of medical providers. One (1) appointee shall be a representative of businesses employing fewer than one hundred (100) employees. One (1) appointee shall be a representative of health insurance agents. Any board member appointed by the commissioner may be removed and replaced by him at any time without cause.

(ii) Three (3) members appointed by the participating insurers, at least one (1) of whom is a domestic insurer.

(iii) The Chair of the Senate Insurance Committee and the Chair of the House Insurance Committee, or their designees, who shall be nonvoting, ex officio members of the board.

(iv) Of those initial members appointed by the Insurance Commissioner, one (1) shall serve for a term of one (1) year, two (2) for a term of two (2) years, and one (1) for a term of three (3) years. Of those initial members appointed by the participating insurers, one (1) shall serve for a term of one (1) year, one (1) shall serve for a term of two (2) years, and one (1) shall serve for a term of three (3) years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

(v) All appointments after the initial term shall be for a term of three (3) years.

(b) The board of directors shall elect one (1) of its members as chairman.

(c) Board members may be reimbursed from monies of the association for actual and necessary expenses incurred by them as members in the manner and amount provided in Section 25-3-41, Mississippi Code of 1972, but shall not otherwise be compensated for their services.

(3) The association shall adopt a plan in accordance with Sections 83-9-201 through 83-9-222 and submit its articles, bylaws and operating rules to the State Department of Insurance for approval. If the association fails to

adopt such plan and suitable articles, bylaws and operating rules within ninety (90) days after the appointment of the board, the State Department of Insurance shall adopt rules to effectuate the provisions of Sections 83-9-201 through 83-9-222; and such rules shall remain in effect until superseded by a plan and articles, bylaws and operating rules submitted by the association and approved by the State Department of Insurance.

(4) Individual board members shall not be liable and shall be immune from suit at law or equity for any conduct performed in good faith and which is within the subject matter over which they have been given jurisdiction.

SOURCES: Laws, 1991, ch. 593, § 6; Laws, 1995, ch. 490, § 6; reenacted and amended, Laws, 1997, ch. 311, § 6; Laws, 2009, ch. 385, § 4; Laws, 2012, ch. 302, § 1, eff from and after passage (approved Mar. 30, 2012.)

Amendment Notes — The 2012 amendment substituted "an eleven-member" for "a nine-member" preceding "board of directors consisting of" at the end of (2)(a); in (2)(a)(i), substituted "Six (6)" for "Four (4)" at the beginning of first sentence, "Two (2)" for "One (1)" at beginning of third sentence, added fourth sentence, and made minor stylistic changes; inserted "initial" preceding "members" in the first and second sentences in (2)(a)(iv); substituted "appointments" for "terms" and "term" for "period" in (2)(a)(v).

COVERAGE FOR TELEMEDICINE SERVICES

SEC.

83-9-351. Health insurance plans in Mississippi to provide coverage for telemedicine services; definitions.

83-9-353. Coverage and reimbursement for store-and-forward telemedicine services and remote patient monitoring services; definitions.

§ 83-9-351. Health insurance plans in Mississippi to provide coverage for telemedicine services; definitions.

(1) As used in this section:

(a) "Employee benefit plan" means any plan, fund or program established or maintained by an employer or by an employee organization, or both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, hospital care or other benefits.

(b) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, and includes the State and School Employees Health Insurance Plan and any other public health care assistance program offered or administered by the state or any political subdivision or instrumentality of the state. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

(c) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, health maintenance organization,

preferred provider organization, managed care organization, pharmacy benefit manager, and, to the extent permitted under federal law, any administrator of an insured, self-insured or publicly funded health care benefit plan offered by public and private entities, and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(d) "Telemedicine" means the delivery of health care services such as diagnosis, consultation, or treatment through the use of interactive audio, video, or other electronic media. Telemedicine must be "real-time" consultation, and it does not include the use of audio-only telephone, e-mail, or facsimile.

(2) All health insurance and employee benefit plans in this state must provide coverage for telemedicine services to the same extent that the services would be covered if they were provided through in-person consultation.

(3) A health insurance or employee benefit plan may charge a deductible, co-payment, or coinsurance for a health care service provided through telemedicine so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(4) A health insurance or employee benefit plan may limit coverage to health care providers in a telemedicine network approved by the plan.

(5) Nothing in this section shall be construed to prohibit a health insurance or employee benefit plan from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's policy.

(6) In a claim for the services provided, the appropriate procedure code for the covered services shall be included with the appropriate modifier indicating interactive communication was used.

(7) The originating site is eligible to receive a facility fee, but facility fees are not payable to the distant site.

SOURCES: Laws, 2013, ch. 478, § 1; Laws, 2014, ch. 436, § 2, eff from and after July 1, 2014.

Amendment Notes — The 2014 amendment added (1)(a) and redesignated the remaining subsections accordingly; and inserted "and employee benefit" in (2) and "or employee benefit" in (3), (4), and (5).

§ 83-9-353. Coverage and reimbursement for store-and-forward telemedicine services and remote patient monitoring services; definitions.

(1) As used in this section:

(a) "Employee benefit plan" means any plan, fund or program established or maintained by an employer or by an employee organization, or both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their benefi-

ciaries, through the purchase of insurance or otherwise, medical, surgical, hospital care or other benefits.

(b) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, and includes the State and School Employees Health Insurance Plan and any other public health care assistance program offered or administered by the state or any political subdivision or instrumentality of the state. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

(c) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, health maintenance organization, preferred provider organization, managed care organization, pharmacy benefit manager, and, to the extent permitted under federal law, any administrator of an insured, self-insured or publicly funded health care benefit plan offered by public and private entities, and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(d) "Store-and-forward telemedicine services" means the use of asynchronous computer based communication between a patient and a consulting provider or a referring health care provider and a medical specialist at a distant site for the purpose of diagnostic and therapeutic assistance in the care of patients who otherwise have no access to specialty care. Store-and-forward telemedicine services involve the transferring of medical data from one (1) site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.

(e) "Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including:

(i) Monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry and other condition-specific data, such as blood glucose;

(ii) Medication adherence monitoring; and

(iii) Interactive video conferencing with or without digital image upload as needed.

(f) "Mediation adherence management services" means the monitoring of a patient's conformance with the clinician's medication plan with respect to timing, dosing and frequency of medication-taking through electronic transmission of data in a home telemonitoring program.

(2) Store-and-forward telemedicine services allow a health care provider trained and licensed in his or her given specialty to review forwarded images and patient history in order to provide diagnostic and therapeutic assistance in the care of the patient without the patient being present in real time. Treatment recommendations made via electronic means shall be held to the same standards of appropriate practice as those in traditional provider-patient setting.

(3) Any patient receiving medical care by store-and-forward telemedicine services shall be notified of the right to receive interactive communication with the distant specialist health care provider and shall receive an interactive communication with the distant specialist upon request. If requested, communication with the distant specialist may occur at the time of the consultation or within thirty (30) days of the patient's notification of the request of the consultation. Telemedicine networks unable to offer the interactive consultation shall not be reimbursed for store-and-forward telemedicine services.

(4) Remote patient monitoring services aim to allow more people to remain at home or in other residential settings and to improve the quality and cost of their care, including prevention of more costly care. Remote patient monitoring services via telehealth aim to coordinate primary, acute, behavioral and long-term social service needs for high-need, high-cost patients. Specific patient criteria must be met in order for reimbursement to occur.

(5) Qualifying patients for remote patient monitoring services must meet all the following criteria:

(a) Be diagnosed, in the last eighteen (18) months, with one or more chronic conditions, as defined by the Centers for Medicare and Medicaid Services (CMS), which include, but are not limited to, sickle cell, mental health, asthma, diabetes, and heart disease;

(b) Have a recent history of costly service use due to one or more chronic conditions as evidenced by two (2) or more hospitalizations, including emergency room visits, in the last twelve (12) months; and

(c) The patient's health care provider recommends disease management services via remote patient monitoring.

(6) A remote patient monitoring prior authorization request form must be submitted to request telemonitoring services. The request must include the following:

(a) An order for home telemonitoring services, signed and dated by the prescribing physician;

(b) A plan of care, signed and dated by the prescribing physician, that includes telemonitoring transmission frequency and duration of monitoring requested;

(c) The client's diagnosis and risk factors that qualify the client for home telemonitoring services;

(d) Attestation that the client is sufficiently cognitively intact and able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data; and

(e) Attestation that the client is not receiving duplicative services via disease management services.

(7) The entity that will provide the remote monitoring must be a Mississippi-based entity and have protocols in place to address all of the following:

(a) Authentication and authorization of users;

(b) A mechanism for monitoring, tracking and responding to changes in a client's clinical condition;

(c) A standard of acceptable and unacceptable parameters for client's clinical parameters, which can be adjusted based on the client's condition;

(d) How monitoring staff will respond to abnormal parameters for client's vital signs, symptoms and/or lab results;

(e) The monitoring, tracking and responding to changes in client's clinical condition;

(f) The process for notifying the prescribing physician for significant changes in the client's clinical signs and symptoms;

(g) The prevention of unauthorized access to the system or information;

(h) System security, including the integrity of information that is collected, program integrity and system integrity;

(i) Information storage, maintenance and transmission;

(j) Synchronization and verification of patient profile data; and

(k) Notification of the client's discharge from remote patient monitoring services or the de-installation of the remote patient monitoring unit.

(8) The telemonitoring equipment must:

(a) Be capable of monitoring any data parameters in the plan of care; and

(b) Be a FDA Class II hospital-grade medical device.

(9) Monitoring of the client's data shall not be duplicated by another provider.

(10) To receive payment for the delivery of remote patient monitoring services via telehealth, the service must involve:

(a) An assessment, problem identification, and evaluation that includes:

(i) Assessment and monitoring of clinical data including, but not limited to, appropriate vital signs, pain levels and other biometric measures specified in the plan of care, and also includes assessment of response to previous changes in the plan of care; and

(ii) Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care.

(b) Implementation of a management plan through one or more of the following:

(i) Teaching regarding medication management as appropriate based on the telemedicine findings for that encounter;

(ii) Teaching regarding other interventions as appropriate to both the patient and the caregiver;

(iii) Management and evaluation of the plan of care including changes in visit frequency or addition of other skilled services;

(iv) Coordination of care with the ordering health care provider regarding telemedicine findings;

(v) Coordination and referral to other medical providers as needed; and

(vi) Referral for an in-person visit or the emergency room as needed.

(11) The telemedicine equipment and network used for remote patient monitoring services should meet the following requirements:

(a) Comply with applicable standards of the United States Food and Drug Administration;

(b) Telehealth equipment be maintained in good repair and free from safety hazards;

(c) Telehealth equipment be new or sanitized before installation in the patient's home setting;

(d) Accommodate non-English language options; and

(e) Have 24/7 technical and clinical support services available for the patient user.

(12) All health insurance and employee benefit plans in this state must provide coverage and reimbursement for the asynchronous telemedicine services of store-and-forward telemedicine services and remote patient monitoring services based on the criteria set out in this section. Store-and-forward telemedicine services shall be reimbursed to the same extent that the services would be covered if they were provided through in-person consultation.

(13) Remote patient monitoring services shall include reimbursement for a daily monitoring rate at a minimum of Ten Dollars ($10.00) per day each month and Sixteen Dollars ($16.00) per day when medication adherence management services are included, not to exceed thirty-one (31) days per month. These reimbursement rates are only eligible to Mississippi-based telehealth programs affiliated with a Mississippi health care facility.

(14) A one-time telehealth installation/training fee for remote patient monitoring services will also be reimbursed at a minimum rate of Fifty Dollars ($50.00) per patient, with a maximum of two (2) installation/training fees/calendar year. These reimbursement rates are only eligible to Mississippi-based telehealth programs affiliated with a Mississippi health care facility.

(15) No geographic restrictions shall be placed on the delivery of telemedicine services in the home setting other than requiring the patient reside within the State of Mississippi.

(16) Health care providers seeking reimbursement for store-and-forward telemedicine services must be licensed Mississippi providers that are affiliated with an established Mississippi health care facility in order to qualify for reimbursement of telemedicine services in the state. If a service is not available in Mississippi, then a health insurance or employee benefit plan may decide to allow a non-Mississippi-based provider who is licensed to practice in Mississippi reimbursement for those services.

(17) A health insurance or employee benefit plan may charge a deductible, co-payment, or coinsurance for a health care service provided through store-and-forward telemedicine services or remote patient monitoring services so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(18) A health insurance or employee benefit plan may limit coverage to health care providers in a telemedicine network approved by the plan.

(19) Nothing in this section shall be construed to prohibit a health insurance or employee benefit plan from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's policy.

(20) In a claim for the services provided, the appropriate procedure code for the covered service shall be included with the appropriate modifier

indicating telemedicine services were used. A "GQ" modifier is required for asynchronous telemedicine services such as store-and-forward and remote patient monitoring.

(21) The originating site is eligible to receive a facility fee, but facility fees are not payable to the distant site.

SOURCES: Laws, 2014, ch. 436, § 1, eff from and after July 1, 2014.

CHAPTER 11

Automobile Insurance

Article 3.	Uninsured Motorist Coverage	83-11-101
Article 11.	Payment of Claims	83-11-551

ARTICLE 1.

CANCELLATION OR NONRENEWAL OF POLICY.

§ 83-11-5. Notice of cancellation.

JUDICIAL DECISIONS

1. In general.

Insurer had an arguable reason for its actions of canceling the insurance coverage after the insurer failed to pay a monthly premium because the Commissioner of Insurance's interpretation of Miss. Code Ann. § 83-11-5, that it was understood as a requirement of reminding customers at least 10 days in advance that they should either timely pay their premiums or make alternative arrangements before the coverage in place expires, was not contrary to the statute's plain language. Keys v. Safeway Ins. Co., — F. Supp. 2d —, 2011 U.S. Dist. LEXIS 13197 (S.D. Miss. Feb. 9, 2011).

§ 83-11-7. Non-renewal.

JUDICIAL DECISIONS

1. In general.

Failure of an insurer to provide the bank, which loaned money to the insured for the purchase of an automobile, with notice of the insurer's non-renewal of the insured's automobile insurance policy did not provide the insured with any rights or cause of action regarding the policy coverage. Alexander v. Aig Agency Auto, Inc, 138 So. 3d 190 (Miss. Ct. App. 2013).

§ 83-11-9. Proof of notice.

JUDICIAL DECISIONS

1. In general.

Insurer was entitled to summary judgment on an insured's coverage claim because the certificate of mailing which the insurer provided was conclusive proof of the insured's receipt of notice of the cancellation by the insurer of the insured's automobile insurance policy, and the insured failed to provide sufficient evidence to create a triable issue of fact to overcome

the presumption of notice. Alexander v. Aig Agency Auto, Inc, 138 So. 3d 190 (Miss. Ct. App. 2013).

ARTICLE 3.

UNINSURED MOTORIST COVERAGE.

SEC.

83-11-101. Automobile liability policies to contain "uninsured motorist" and property damage provisions; rejection of uninsured motorist coverage.
83-11-102. Purchase of single-limit, nonstacking uninsured motorist insurance coverage for four or more vehicles in lieu of uninsured motorists coverage for each vehicle.

§ 83-11-101. Automobile liability policies to contain "uninsured motorist" and property damage provisions; rejection of uninsured motorist coverage.

(1) No automobile liability insurance policy or contract shall be issued or delivered after January 1, 1967, unless it contains an endorsement or provisions undertaking to pay the insured all sums which he shall be legally entitled to recover as damages for bodily injury or death from the owner or operator of an uninsured motor vehicle, within limits which shall be no less than those set forth in the Mississippi Motor Vehicle Safety Responsibility Law, as amended, under provisions approved by the Commissioner of Insurance; however, at the option of the insured, the uninsured motorist limits may be increased to limits not to exceed those provided in the policy of bodily injury liability insurance of the insured or such lesser limits as the insured elects to carry over the minimum requirement set forth by this section. The coverage herein required shall not be applicable where any insured named in the policy shall reject the coverage in writing and provided further, that unless the named insured requests such coverage in writing, such coverage need not be provided in any renewal policy where the named insured had rejected the coverage in connection with a policy previously issued to him by the same insurer.

(2) No automobile liability insurance policy or contract shall be issued or delivered after January 1, 1980, unless it contains an endorsement or provisions undertaking to pay the insured all sums which he shall be legally entitled to recover as damages for property damage from the owner or operator of an uninsured motor vehicle, within limits which shall be no less than those set forth in the Mississippi Motor Vehicle Safety Responsibility Law, as amended, under provisions approved by the Commissioner of Insurance; however, at the option of the insured, the uninsured motorist limits may be increased to limits not to exceed those provided in the policy of property damage liability insurance of the insured or such lesser limits as the insured elects to carry over the minimum requirement set forth by this section. The coverage herein required shall not be applicable where any insured named in the policy shall reject the coverage in writing and provided further, that unless the named

insured requests such coverage in writing, such coverage need not be provided in any renewal policy where the named insured had rejected the coverage in connection with a policy previously issued to him by the same insurer.

The property damage provision may provide an exclusion for the first Two Hundred Dollars ($200.00) of such property damage; however, the uninsured motorist provision need not insure any liability for property damage, for which loss the policyholder has been compensated by insurance or otherwise.

(3) The insured may reject the property damage liability insurance coverage required by subsection (2) and retain the bodily injury liability insurance coverage required by subsection (1), but if the insured rejects the bodily injury liability coverage he may not retain the property damage liability coverage. No insured may have property damage liability insurance coverage under this section unless he also has bodily injury liability insurance coverage under this section.

(4) In the course of the sale or issuance of any automobile liability insurance policy, insurers shall inform the named insured or applicant, on a form approved by the Department of Insurance, of the benefits of and reasons for electing to purchase uninsured motorist coverage. If the insured named in the policy wishes to reject uninsured motorist coverage, such form shall be signed by or on behalf of the named insured. If this form is signed by or on behalf of the named insured, it is binding upon all persons insured by the automobile liability insurance policy and it shall be presumed that there was an informed, knowing rejection and waiver of uninsured motorist coverage.

SOURCES: Codes, 1942, § 8285-51; Laws, 1966, ch. 524, § 1; Laws, 1974, ch. 393; Laws, 1979, chs. 429 § 2, 432; Laws, 2014, ch. 428, § 1, eff from and after July 1, 2014.

Amendment Notes — The 2014 amendment added (4).

JUDICIAL DECISIONS

15. Waiver of uninsured motorist coverage.

Fact issues as to whether an insurance agent explained the costs and benefits of uninsured motorist (UM) coverage and whether the insureds gave a knowing and intelligent waiver of UM coverage precluded summary judgment on a UM claim where the insureds testified they did not read the provision before signing a waiver and that the agent did not explain the waiver to them. Honeycutt v. Coleman, 120 So. 3d 358 (Miss. 2013).

Any waiver of uninsured motorist (UM) coverage must be made knowingly, intelligently, and in writing, with the insurer bearing the burden of proof, which may be met by establishing that the insurer provided an explanation, appropriate to the client, of UM coverage or that the client was fully knowledgeable through other sources of the purposes and benefits of UM coverage; any document signed by the client that states that an explanation was given to the client may be considered, but is not dispositive. Whether a client made a knowing and intelligent waiver of UM coverage is a question of fact for the fact-finder. Honeycutt v. Coleman, 120 So. 3d 358 (Miss. 2013).

§ 83-11-102. Purchase of single-limit, nonstacking uninsured motorist insurance coverage for four or more vehicles in lieu of uninsured motorists coverage for each vehicle.

(1) An insured in an automobile liability policy that covers four (4) or more vehicles may elect to purchase, and an insurer may offer, single-limit, nonstacking uninsured motorist insurance coverage covering all vehicles listed in the policy for a single amount of uninsured motorist coverage. The single uninsured motorist coverage limit must be in an amount of no less than the liability limits required under the Mississippi Motor Vehicle Safety Responsibility Law for four (4) vehicles combined. No matter how many vehicles are listed in or covered by the policy, the policy shall provide only one (1) single limit of uninsured motorist coverage to an injured person, or for property damage, or both, for any one (1) accident. The single limit of uninsured motorist coverage provided by the single-limit, nonstacking uninsured motorist insurance coverage may, where appropriate, be aggregated with or stacked with uninsured motorist insurance coverage available from other policies.

(2) In the course of the sale or issuance of single-limit, nonstacking uninsured motorist insurance coverage, insurers shall inform the named insured or applicant, on a form approved by the Department of Insurance, of the limitation on stacking imposed and that such coverage is an alternative to coverage without such limitation, and such form shall be signed by or on behalf of the named insured or applicant. If this form is signed by or on behalf of a named insured or applicant, it is binding upon all persons insured by the uninsured motorist coverage and it shall be presumed that there was an informed, knowing acceptance of such limitation. When the named insured or applicant has initially accepted such limitation on stacking, such acceptance shall apply to any policy from the same insurer, including sister insurers in the same holding company, which renews the coverage, extends the coverage or changes covered vehicles unless and until the named insured requests in writing a change to stackable uninsured motorist coverage. Endorsements to the coverage language that do not change the uninsured motorist coverage language shall not be considered a new policy for purposes of determining whether a new acceptance form is necessary.

SOURCES: Laws, 2002, ch. 390, § 1; Laws, 2013, ch. 507, § 1, eff from and after July 1, 2013.

Amendment Notes — The 2013 amendment substituted "four (4)" for "ten (10)" in the first and second sentences of (1).

§ 83-11-103. Definitions.

JUDICIAL DECISIONS

9. Miscellaneous.

In a coverage dispute, a brother was not entitled to uninsured motorist benefits under a sister's policy with an insurer because the brother was not a resident of the sister's household nor she in his household, and as such, the brother was not an "insured" as defined in the Uninsured Motorist Act, Miss. Code Ann. § 83-11-103(b); although the sister helped take care of the brother in his residence on a periodic basis after an accident, the sister never intended to abandon her residence, which was across the street from the brother's. Robinson v. State Farm Mut. Auto. Ins. Co., 52 So. 3d 416 (Miss. Ct. App. 2010), writ of certiorari dismissed by 56 So. 3d 574, 2011 Miss. LEXIS 159 (Miss. 2011).

ARTICLE 11.

PAYMENT OF CLAIMS.

SEC.

83-11-551. Addition of name of business repairing automobile or lienholder as payee on check; obtaining title where there is total loss settlement [Repealed effective July 1, 2017].

§ 83-11-551. Addition of name of business repairing automobile or lienholder as payee on check; obtaining title where there is total loss settlement [Repealed effective July 1, 2017].

(1) In cases in which there is not a total loss, when there are one or more lienholders shown in the policy or confirmed in writing by the insured before the loss, an insurer paying a claim under automobile physical damage coverage or automobile collision coverage, as such terms are defined in Section 83-11-1, shall add as a payee on the check, in addition to the name of the insured, the name of the business or other entity repairing the automobile or the name of the lienholder or lienholders.

(2) In cases of a total loss, when there are one or more lienholders (a) shown in the policy, (b) confirmed in writing by the insured before the loss, or (c) shown on the vehicle title recorded with the Mississippi Department of Revenue, an insurer paying a claim under automobile physical damage coverage or automobile collision coverage, as such terms are defined in Section 83-11-1, shall add as a payee on the check, in addition to the name of the insured, the name of the lienholder or lienholders.

(3) If the insured disputes the existence of any lien, it is the insured's responsibility to have the liens released. When payment is made to a lienholder, the lienholder shall pay any balance owed to the debtor within thirty (30) days after receipt of the check. However, in the case of a total loss, the insurer may issue separate checks to the lienholder and to the insured for the amount of each party's financial interest in the vehicle. This section shall not apply to the repair or replacement of glass in the vehicle.

(4) If an insurance company makes a total loss settlement on a motor vehicle, the owner or lienholder of the motor vehicle shall forward the properly endorsed certificate of title to the insurance company within fifteen (15) days after receipt of the settlement funds.

(5)(a) If an insurance company is unable to obtain the properly endorsed certificate of title within thirty (30) days after disbursing a total loss settlement payment for a motor vehicle that does not have a lien or encumbrance, the insurance company or its agent may request the Department of Revenue to issue a salvage certificate of title or a parts-only certificate of title for the vehicle.

(b) The request under paragraph (a) of this subsection shall:

(i) Be submitted on each form required by and provided by the Department of Revenue;

(ii) Document that the insurance company has made at least two (2) written attempts to obtain the certificate of title and include the documentation with the request;

(iii) Include any fees applicable to the issuance of a salvage certificate of title or a parts-only certificate of title; and

(iv) Be signed under penalty of perjury.

(6)(a) If an insurance company is unable to obtain the properly endorsed certificate of title within thirty (30) days after disbursing a total loss settlement payment for a motor vehicle that has a lien or encumbrance, the insurance company or its agent shall submit documentation to the Department of Revenue from the claims file that establishes the lienholder's interest was protected in the total loss indemnity payment for the claim.

(b) The documentation under paragraph (a) of this subsection shall be:

(i) Submitted with a request for a salvage certificate of title or a parts-only certificate of title for the vehicle; and

(ii) The requirements under subsection (5)(b) of this section.

(7) Upon receipt of a properly endorsed certificate of title or a properly executed request under subsection (5) of this section, the Department of Revenue shall issue a salvage certificate of title or a parts-only certificate of title for the vehicle in the name of the insurance company.

(8) The Department of Revenue may promulgate rules, regulations and forms for the administration of subsections (4) through (6) of this section.

(9) This section shall stand repealed from and after July 1, 2017.

SOURCES: Laws, 2007, ch. 594, § 1; Laws, 2009, ch. 461, § 1; Laws, 2012, ch. 392, § 1; Laws, 2014, ch. 435, § 1, eff from and after July 1, 2014.

Amendment Notes — The 2012 amendment substituted "Department of Revenue" for "Mississippi State Tax Commission" in (2); and added (4) through (9).

The 2014 amendment, in (9), substituted "from and after" for "on" and extended the repealer provision from "July 1, 2014" to "July 1, 2017."

CHAPTER 17

Insurance Agents, Solicitors, or Adjusters

Article 9. Licensing of Insurance Adjusters 83-17-401

Article 1.

General Provisions.

§ 83-17-1. Agent defined.

JUDICIAL DECISIONS

4. Agents' knowledge as imputable to insurer-generally.

Insurer was not aware that there was a lienholder on an insured vehicle because, although knowledge acquired by a soliciting agent in the course of the agent's employment in soliciting insurance and preparing and transmitting applications was ordinarily imputed to the insurer, the agent never said that the agent was aware that there was a lienholder. Alexander v. Aig Agency Auto, Inc, 138 So. 3d 190 (Miss. Ct. App. 2013).

Article 9.

Licensing of Insurance Adjusters.

Sec.

83-17-401. Definitions.
83-17-407. Waiver of license requirement for adjuster licensed in another state; prohibition against denial of reciprocity for applicant licensed in another state solely because applicant is not resident of the United States.

§ 83-17-401. Definitions.

As used in this article, unless the context otherwise requires:

(a) "Adjuster" means any person who, as an independent contractor, or as an employee of an independent contractor, adjustment bureau, association, insurance company or corporation, managing general agent or self-insured, investigates or adjusts losses on behalf of either an insurer or a self-insured, or any person who supervises the handling of claims. "Adjuster" shall not include:

(i) An attorney-at-law who adjusts insurance losses from time to time and incidental to the practice of law, and who does not advertise or represent that he is an adjuster;

(ii) A salaried employee of an insurer who is regularly engaged in the adjustment, investigation or supervision of insurance claims;

(iii) Persons employed only for the purpose of furnishing technical assistance to a licensed adjuster, including, but not limited to, photographers, estimators, private detectives, engineers, handwriting experts and attorneys-at-law;

(iv) A licensed agent or general agent of an authorized insurer who processes undisputed or uncontested losses, or both, for such insurer under policies issued by the licensed agent or general agent;

(v) A person who performs clerical duties with no negotiations with the parties on disputed or contested claims, or both;

(vi) Any person who handles claims arising under life, accident and health insurance policies;

(vii) Any person who is a multiperil crop insurance adjuster; or

(viii) Any person who collects claim information from, or furnishes claim information to, insureds or claimants, and who performs data entry including entering data into an automated claims adjudication system, if the person is an employee of a licensed independent adjuster or its affiliate where no more than twenty-five (25) such persons are under the supervision of one (1) licensed independent adjuster or licensed agent. A licensed agent who is acting as a supervisor and adjusting portable electronics insurance claims in accordance with this subparagraph does not need to be licensed as an adjuster.

(b) "Insurer" means any insurance company or self-insured.

(c) "Commissioner" means the Commissioner of Insurance.

(d) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims which:

(i) May only be utilized by a licensed independent adjuster, licensed agent or supervised persons operating in accordance with paragraph (a)(viii) of this section; and

(ii) Must comply with all claims payment requirements of the insurance code; and must be certified as compliant with this section by a licensed independent adjuster that is an officer of a licensed business entity under this chapter.

SOURCES: Laws, 1993, ch. 433, § 1; Laws, 2011, ch. 474, § 1; Laws, 2012, ch. 313, § 1, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment added (a)(viii); added (d); and made minor stylistic changes.

§ 83-17-407. Waiver of license requirement for adjuster licensed in another state; prohibition against denial of reciprocity for applicant licensed in another state solely because applicant is not resident of the United States.

The commissioner may waive any license requirement for an applicant with a valid license from another state having license requirements substantially equivalent to those of this state. No applicant with a valid license from another state shall be rejected solely on the basis that the individual is not a resident of the United States of America.

SOURCES: Laws, 1993, ch. 433, § 4; Laws, 2012, ch. 313, § 2, eff from and after July 1, 2012.

Amendment Notes — The 2012 amendment added the last sentence.

Index

A

ACCIDENT AND HEALTH INSURANCE.
Assignment of benefits.
Commercial insurers to honor assignments, §83-9-3.
Policies.
Disapproval of form, rider or endorsement by commissioner, §83-9-4.
Prescriptions.
Prior authorization for prescription drug benefits.
Form, §83-9-6.3.
Telemedicine services.
Coverage required, §83-9-351.
Home telemonitoring programs, §83-9-353.
Remote patient monitoring services, §83-9-353.
Store-and-forward telemedicine services, §83-9-353.
Terminal condition, diagnosis of.
Restricting coverage for medically appropriate treatment, prohibited, §83-9-22.

I

INSURANCE COMPANIES.
Financial and market analysis review, §83-5-205.
Confidentiality of information obtained or produced by commissioner, §83-5-209.
Property and casualty actuarial opinion act, §§83-5-501 to 83-5-505.
Registration and examination of insurers.
Enterprise risk.
Defined, §83-6-1.
Report.
Annual enterprise risk report, §83-6-5.

INSURANCE COMPANIES —Cont'd
Registration and examination of insurers —Cont'd
Management of insurers subject to registration.
Domestic insurers, §83-6-26.

L

LIFE INSURANCE.
Unclaimed life insurance benefits act, §§83-7-301 to 83-7-313.

P

PROPERTY AND CASUALTY INSURANCE.
Actuarial opinion and report.
Property and casualty actuarial opinion act, §§83-5-501 to 83-5-505.
Hurricane deductibles, uniform policy language for, §83-2-3.

T

TELEMEDICINE.
Accident and health insurance.
Coverage for telemedicine services, §83-9-351.
Home telemonitoring programs, §83-9-353.
Remote patient monitoring services, §83-9-353.
Store-and-forward telemedicine services, §83-9-353.

TERMINAL ILLNESS.
Health insurance.
Restricting coverage for medically appropriate treatment, prohibited, §83-9-22.

U

UNCLAIMED LIFE INSURANCE BENEFITS ACT, §§83-7-301 to 83-7-313.